STATE OF MICHIGAN
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
CERTIFICATE OF NEED
- -
COMMISSION MEETING
Tuesday, December 14, 2004
Lansing, Michigan

APPROVED TRANSCRIPT

COMMISSION MEMBERS:

Renee Turner-Bailey - Chairperson
Norma Hagenow - Vice-Chairperson
Peter Ajluni, D.O.
Roger G. Andrzejewski
Brad Cory
James K. Delaney
Dorothy Deremo
Edward G. Goldman
James Maitland
Michael Sandler, M.D.
Michael Young, D.O.

DEPARTMENT OF ATTORNEY GENERAL STAFF:

Ron Styka
Todd Cohen

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH STAFF:

Jan Christensen
William J. Hart, Jr.
Brenda Rogers
Larry Horvath

PUBLIC ATTENDENCE:

Approximately 46 people were in attendance.

(Meeting scheduled to start at 10:00 a.m.; actual start time was 10:10 a.m.)

MS. TURNER-BAILEY: Good morning. I want to call the December 14th meeting of Certificate of Need Commission to order, 10:10, and welcome everyone here today. Before we get into the review of the agenda, I have just a few announcements to make -- a couple announcements to make. The first is the only copies that the department is making are for items that we're taking action on today, or that we expect to take action on today. So for those of you who have items that you need to be distributed, you'll need to bring your own copies in the future, unless, of course, it's, you know, language or something like that, which I can't -- I don't know what that would be. But just to let you know, that's the reason. If you want copies, then you'll need to submit a FOIA request. So those are your two options; submit a FOIA request, bring your own copies in the future. Okay? And the second thing is -- the announcement is actually for the commissioners. There are mics that are sitting on tripods. And we're asking that you don't move those mics, because those are for the court reporter. Those are not for projection purposes. There are mics that are sitting on the table that you'll need to pick up and speak into if you need to be heard by the group out there. Okay? Thank you. And the third is not really an announcement, but a special introduction. I'd like to introduce Dr. Gary Dillon who is a senator from Indiana. He's come to observe our proceedings today and hopefully get some

thoughts about what we're going to do in Indiana. So I'd just like to take a moment to welcome you here, Dr. Dillon. Thank you for coming. At this point, I'd like to ask that everyone take a review of the agenda. As you can see, we have quite a full agenda today. Are there any changes, corrections? If not, I'll accept a motion to accept the agenda as written.

MR. MAITLAND: Maitland moves that the agenda be accepted.

DR. SANDLER: Sandler seconded.

MS. TURNER-BAILEY: Moved by Commissioner Maitland, seconded by Commission Sandler that we accept the agenda. Just another comment, as I mentioned we do have a very full agenda. When we get to the public comment sections of each area, I am going to ask everyone to limit the length of your comment to three minutes. I'm going to try and do it without a timer for the first two speakers. And if we can't get it, I'm going to ask Brenda to make up little signs to put up. And then if that doesn't work, I'm going to ask Brenda to go get her hook to come and help us to stay on track here today. So I'd appreciate your cooperation with that request. Are there any declarations of conflicts of interest?
(No verbal response)

MS. TURNER-BAILEY: Okay. Hearing none, we'll move on. Item number IV in the agenda is a review of minutes of the meeting of September 14th. At this time, if any of the commissioners have any changes, additions or corrections to the minutes, I'd hear them. Yes, Commissioner Cory?

MR. CORY: On page 2 of 24, under my comments, third sentence, "One thing that I would like to do is to give kudos to all the parties who have participated in this process" period, it was written in an unclear manner.

MS. TURNER-BAILEY: Okay.

MS. ROGERS: So you want to --

MR. CORY: Also --

MS. ROGERS: -- change the comma to a period?

MS. TURNER-BAILEY: Yeah. He said, "kudos to all who participated in this process" period.

MR. CORY: And scratch off "the parties that" I believe, and start the next sentence, "I've never seen the spirit of cooperation that prevailed throughout this process between the for-profit associations and not- -- non-profit associations, the county medical care facility council and the Department." Page 5 of 24, middle paragraph under "Reg Carter," "My name is Reg Carter, and I'm the" -- he's a CEO. He's either executive vice-president or executive director. Those are all the comments I have.

MS. TURNER-BAILEY: Thank you. Are there any other additions or corrections to the minutes? Commissioner Deremo?

MS. DEREMO: On page 17 of 24, the first sentence should read, "Mr. Meeker, with respect to the proposals, I think there's going to need to be a fine balance, because what I can see as your work" -- excuse me -- "when I can see your work is drawing to a close that you would be inundated," et cetera.

MS. TURNER-BAILEY: Okay. So delete the "as."

MS. DEREMO: Delete -- in the first "with respect," delete the "with the proposals" -- "respect" -- and insert "to the proposals."

MS. TURNER-BAILEY: Any other additions, changes? (No verbal response)

MS. TURNER-BAILEY: Is there a motion?

MS. DEREMO: So moved.

MR. CORY: Supported.

MS. TURNER-BAILEY: It's been moved and supported that we accept the agenda with -- the corrections shown. All those in favor signify by raising your right hand.

ALL: (Affirmative response)

MS. TURNER-BAILEY: Opposed?

ALL: (Negative response)

MS. TURNER-BAILEY: I'd ask for the Standard Advisory Committee final report, proposed language, Dale Steiger.

MR. STEIGER: Good morning.

MS. TURNER-BAILEY: Good morning.

MR. STEIGER: My name is Dale Steiger; I'm with Blue Cross and Blue Shield of Michigan. And I'm also, fortunately or unfortunately, the chair of the first Standard Advisory Committee for hospital beds, the first committee that was appointed under the new rules. We're going to be showing transparencies for the next few minutes. So I'm not sure how folks want to handle this up front, but Bob Meeker is there for a purpose. (Off the record interruption)

MR. STEIGER: Okay. As indicated in the agenda, this is the final report and the summary of recommendations. It was put together by the Standard Advisory Committee, whose life ended on November 10, 2004. I'm going to try to be very brief today; I know we have a full agenda. We have four other individuals from the SAC -- (Off the record interruption)

MR. STEIGER: Thank you. We have four other individuals from the SAC who are also going to walk through portions of details of some of the recommendations. I'd also like to point out that we have summaries -- paper summaries of the -- generally speaking, what I'm going to go over this morning back on the table. They have been placed there a little bit late, but anybody that wants to pick up a copy, please feel free. Over the last week or so, the Commission received a summary of our recommendations that we're going to go through today, and also the full-blown report. I was going to ask for a show of hands as to the folks who had read the full-blown report and if it was less than 50 percent, I was going to go through it page by page. But I don't think we probably ought to do that. The report is fairly long. Some people have told me that it is too long. But I wanted the document -- I wanted the report to document all of the effort and the thinking of the various committees and subcommittees that have worked on the various elements of the charge that you gave us. The report is -- particularly in the beginning, the report is structured to be responsive to each specific element that we've identified in the charge. And hopefully as you've seen by now, part III -- and this is the long document which we won't get into today, but part III of the report lists findings and recommendations for each specific element of the charge. As I mentioned, we're not going to go through the long document today, but I did want to note at the beginning of the report that we have lists of names of all the individuals who participated in the effort over the last -- seven months is what it amounts to. I would point out that I somehow or other forgot to include Brenda Rogers in the list of the MDCH staff, so I want to indicate right now that Linda -- Linda's my wife -- that Brenda should have been on the list because as we all know, anybody who's worked in this process knows that without Brenda -- we couldn't have gotten this far without her. And it also occurred to me that I neglected to include the names of Michigan State faculty that have assisted us so well in this work. Bob Meeker, I'm sure, when he goes through his piece of it, will indicate who participated from Michigan State. Let's jump right now to the SAC recommendations, which I will summarize in the order in which they appear in the charge. As I said, I'll be followed by Bob Meeker, Maureen Halligan, Peg Reihmer and Bob Asmussen, who will each briefly expand on a portion of our recommendations. I do want to mention one thing. It occurred to me as we were writing the detail that

you see in the various documents -- and that is that the essence of our charge was to look at the bed need standards, to look at the whole bed need process and determine if there needed to be any exceptions developed for any reason whatsoever. But the intent of the charge was to look at whether we need to develop exceptions to the current bed need methodology, which you all approved, I believe, in March of this year, based on a presentation which we made about a year ago. So the issue was exceptions. The SAC has looked at all of the various issues and concluded that there really are two exceptions for the bed need methodology. Those two exceptions really are the basis of what we're going to go through today on a positive basis. The first part of the charge, increase of licensed beds in a hospital licensed under 215, the detail of our thinking is in the report. This is the high-occupancy issue and I think most people over the last two years, if you've been involved in the process, you're familiar with the high-occupancy issue. The SAC considered this over the period of its life and we would like the -- we are recommending that the commission approve the high-occupancy exception to the acute care bed need methodology as proposed in the standards. I realize Brenda may go through the standards later on; the standards have been issued. But we're recommending approval. We're also recommending that the stipulation be included that high-occupancy hospitals acquire beds that are currently licensed whenever possible from somewhere else. Maureen Halligan will go into details on this issue in the second -- or the third part of our presentation, so that's all I'm going to go over right now. The second part is -- the second part of the charge is the physical relocation of hospital beds from one licensed site to another geographic location. "Another geographic location," we interpret it as being a non-licensed site. So essentially this particular part of the charge, if approved, would have created new hospitals without going through the need process. Because they're -- we would be taking licensed beds, moving it to a particular location outside the replacement zone which currently doesn't have any licensed facilities. And now, as we'll note farther back in another portion of the charge, this particular part of the charge dealt with two proposals that the SAC considered. One is the Pontiac Osteopathic proposal, and the other is a -- was a presentation by Unity Health. The SAC concluded that this was the portion of the charge that dealt with those two discussion points, and our recommendation is that the Commission take no further action on this. We don't believe that there is any need for any change in this standard, and we're recommending that the standard remain the same. The third part of the charge, replacement beds in a hospital licensed under Part 215, the SAC concluded that this part of the charge had to do with any possible revision in the two-mile replacement zone. As you can see by the recommendation, after long discussion, the SAC has concluded that the Commission should take no further action on this charge -- this part of the charge. Basically there is no needs for any change in the bed need standards and the replacement zone should remain as it is in the standards. The fourth part of the charge, a little more complicated, "assure appropriate accessibility to health care," and we interpreted that as being assure appropriate accessibility to hospital beds, since this was a hospital bed Standard Advisory Committee. Our charge here -- our issue here was to try and determine are there areas in the State of Michigan where access to hospital beds is inappropriate, or is not appropriate. Obviously, the first issue would be to figure out how you determine what's appropriate and what's not. Bob Meeker is going to get into this in much more detail. But you can see the recommendations there, that we approve two different things. And I wanted to point out that I was -- I hate to say -- use the word "proud of the SAC," but I think that the entire SAC needs kudos, as Mr. Cory mentioned before. Basically we went through -- with the help of the Michigan State people and the workgroup that Bob Meeker chaired, along with Maureen Halligan, the SAC finally approved this methodology without really knowing what the results were. So the criteria was developed for accessibility. The criteria was developed, how you measure all those kinds of things. And after pretty significant discussion, the SAC voted to approve the methodology and actually as of two or three days ago, we still weren't sure what the results were going to be; and I think the Department is going to go through that. Perhaps as Bob is going through his piece of it, the Department will indicate which areas of the state have finally been determined to be victims of inadequate access to hospital beds. But our recommendation is that the Commission approve the limited area access exception to the bed need methodology. It's presented in the standards in great detail. And we also recommend that the Commission approve the comparative review criteria. And this comparative review criteria would be for applicants who are applying for hospital beds in the limited area -- limited access area exception that we hope you approve in Item 1. The SAC concluded that we needed to have this comparative review criteria in case there were more than one applicant. Peg Reihmer will discuss in -- well, not in detail, but Peg Reihmer will go through it -- through the criteria towards the end of our presentation. The next item had to do with a proposal that had been put forth; I believe it was last spring or early last summer. It's an addendum for hospital beds and related CON standards called the "Special Bed Allocation." That was put forth by the Commission -- the Commission charged the SAC, if you will, with taking a look at that specific proposal, as you can see by Motion Number 1 up there, to submit the

draft hospital beds language -- and that basically was the Special Bed Allocation -- submit that language to the Standard Advisory Committee for its review and recommendation as part of the charge. Basically the SAC, after long discussion, considered that particular issue. And our recommendation is that this particular language not go forward and that the Commission not approve that particular proposal. Item Number 6, that the Department be authorized to immediately forward all new proposals, decisions and ideas, et cetera, essentially, as you can see under the recommendation there, we had presentations by Pontiac Osteopathic. We also had a presentation by the Unity Health folks. Essentially after listening to both presentations and a proposal from Pontiac Osteopathic, the SAC has concluded that the Commission should take no further action on these proposals. We believe that with the acute care bed need methodology and with the -- hopefully the access exception which we hope you will approve today -- with those two portions of the bed needs standards, that there needs to be no other changes to the standards that would allow new hospitals, essentially. Item Number 7, as you all realize, this is probably the fastest work that any significant Standard -- well, certainly this is the first Standard Advisory Committee, but if you go back to the old ad hoc process, I think this group of folks did more work in six months than most other committees that I've been a part of over the years, because we knew we had a deadline. I'm not advocating deadlines, but we knew we had a deadline and I think the committee worked very hard to meet that deadline. There were some other issues that came up as we went through. There were some proposals that were made late in the process by other organizations that we really did not have time to flesh out real well. So basically, believe it or not, we are advocating and recommending that the Commission appoint another advisory committee, or at least make modifications in the work plan next year -- we're not going to go through them right now, Bob; pull that -- that the Commission approve additional work next year, possibly with the Michigan State faculty. But we believe that there are certain issues that need to be dealt with in the future and we're recommending that the Commission consider those issues and approve work next year. I'm not going to go into them right now because Bob Asmusssen is -- at the end of the process here will deal with those issues and go through them in some detail. We're going to flip -- that essentially is all the SAC's recommendations. Since the major part or a very, very significant part of our work is the limited access area exception to the bed need methodology, we felt it would be reasonable to go through that in a bit more detail. So Bob Meeker, along with Maureen Halligan, had been charged early on with being the SAC's representatives to the Michigan State folks. And very early on in the process, after we got started with this exception, we concluded that a workgroup would be very helpful. So we appointed -- we actually convened -- I won't say "appointed," because we didn't appoint specific members, but we convened a workgroup that would go through all of these various issues, chaired by Meeker and Halligan. And Bob is going to go through, in some detail, the logic in this exception and what the results would be. And I'm not sure, Brenda, whether you're going to present the results or Mr. Nash, but we'll get through it. With that, let's turn it over to Bob.

MR. MEEKER: Thanks, Dale. It's been quite an experience chairing this group. As you can see in front of us, the SAC gave the workgroup this specific charge, to identify pockets of Michigan population which have inadequate access to basic hospital services, and also these pockets have to represent a minimum critical mass of demand for inpatient acute care. There are clearly two parts of this task, and we'll talk about them individually. I'd like to talk, just for a moment, about the process. I think on pages 6 and 7 of the document that you were given are a list of all the people that participated in the workgroup. There were about 15 people who were very regular members. But I think that it's safe to say that we proceeded objectively without any preconceived notions of what the outcome should be, and we let the chips fall as they may. So I'd like to go the next slide, please, Dale, which says, "Okay. If we're supposed to find these areas that don't have adequate access to basic hospital services, how do we define that?" Well, first of all we decided that basic hospital services consisted of acute care, and 24-hour emergency services. So if you're right across the street from a, say, specialty hospital that didn't have an emergency department, you were not felt to have adequate access, necessarily, to basic hospital services. So we started with just those -- looking at just those hospitals that have acute care, 24-hour emergency. And then through a lot of discussion, we said, "Well, what's good access?" We looked at some of the literature, some of which goes back to early planning days in the 70's. We looked at some standards that the Veterans Administration uses now. And we determined that an acceptable maximum average travel time to a hospital is 30 minutes. So that's to say that if you're -- if you're not within a 30-minute travel time of a hospital, you do not have adequate access. So that was the first part of our task. Then the second part of the task -- well, that was operationalized with help from the M.S.U. department of geography, particularly Dr. Richard Groop, Dr. Ashton Shortridge and Dr. Joe Messina. Dr. Messina is here today and would be available to answer questions, if people have any questions about this whole process as far as defining these limited access areas. So as I said, we

determined that basic hospital services are hospitals with emergency departments and 24-hour acute care beds. M.S.U. was given the location of all the hospitals that met those requirements that currently are located in the state. They were able to plot those in a statewide map and then using a typology of urban and rural roads which is currently used by the Department of Transportation within the state to determine what the travel times actually were from any point to these particular hospitals. Now, the model assumed that the average speed on these roads is the posted speed limit. Now, we all know that that's not case, that actually the speed is quicker than that in most cases. But there also are times of the day and places within the state where the speeds are not the posted speed limits; that they are slower than that because of congestion and other things. To counterbalance that -- well, we went through possibilities, "Well, we could take the speed limit and we could discount it by 25 percent or 50 percent, and what would be the justification for any of those percentages?" And, after all, we're looking at over the course of a 24-hour period, not at any one point in time. The folks from Michigan State kind of rescued us by suggesting, "Well, look, there are different kinds of roads throughout the state. Why don't we assume that the travel is being done on the slowest possible route?" And I should say that the whole state was sort of divided up into one kilometer by one kilometer squares, so it was a pretty fine degree of measurement, so that within each of those squares, the assumption is that the person going from wherever they were to the hospital would be using the slowest possible route, rather than the quickest possible route. And that way, we felt that that counterbalanced any concerns about congestion and varying speeds at varying times of the day. Using this approach, M.S.U. was able to -- the M.S.U. geographers were able to plot all the areas that were within, or more importantly, without -- or beyond a 30-minute travel time to existing hospitals. And we've called those "limited access areas." They're defined as groupings of contiguous zip code areas and partial zip code areas. Now, Dale, if you would show the map -- and we'll be referring back to this map -- the dark areas on the map are the areas outside of 30 minutes. The little dots are actually hospital locations. And so you can see that, you know, there's an area of some size in western St. Clair County; there's another area kind of in the middle of the state, there's one over just north of Grand Rapids, there are what have been referred to as the "kissing seahorses" around Cadillac. There are other areas in the northern part of the state. There's a large area west of Alpena, and then, not surprisingly, much of the Upper Peninsula. And we could say, "Okay. Well, there are the limited access areas." Well, if you recall back to the definition of what we were supposed to do, we were supposed to find areas that were outside of reasonable access. But we were also supposed to find areas that had at least a minimum critical mass of population that could support a hospital. So then we had to go back and say, "Okay. Well, what are the requirements or what are the criteria for determining that?" And that would be on the next slide. We determined that the minimum critical mass of hospital -- of an LAA or limited access area has to be at least 50,000 people. Using very, very rough sort of conversion, 50,000 people, more or less, translates into 100 hospital beds. I mean, you know, that's going to vary, but that's a very crude determination. So we said 50,000 people is really the minimum that one of these areas should be. If there's, you know, a pocket of 10,000 people, that's too bad, but that's not enough to really support a hospital. Secondly, then, once we determined what -- which of those areas do meet the threshold of 50,000 people -- and we also decided to use not historic population, but rather the projected population for the planning year as defined in the standards. So generally that's five years in advance -- or five years in the future of the most recent year that we have data for. Then when we find the areas that have 50,000 population, we just essentially apply the existing acute bed care need methodology for that population. And then as we have the Department reviewing applications, we have suggested minimum hospital sizes. In some cases, the need in the area might be less than one of these hospital sizes, in which case that -- you default to that bed need. But in metropolitan areas, we felt it needed to be at least a 100- bed hospital, and micropolitan and rural areas needs to be at least a 50-bed hospital, unless the applicant is simultaneously applying to be a critical access hospital, which is a Federal designation, and then the minimum would be the size determined for a critical access hospital. Furthermore, we felt that within these areas -- and if you recall the map, some of those areas are quite large -- that a significant portion of the populations of the limited access area had to be served by the proposed new hospital. So, for instance, you couldn't be right at the edge of a limited access area so that you cover a lot of population or a lot of folks who are really quite well served, and you're only just making a small dent in the limited access area. So we felt that in the metropolitan areas, wherever the applicant proposes to put their hospital has to have at least 50,000 people of the people in the limited access area within 30 minutes travel time of their proposed location. In micropolitan and rural areas, we felt, obviously because of the more -- the less densely populated area, that it should be -- 50,000 people within 60 minutes of travel time needed to be within the limited access area. So, Dale, if you would, put the map back and we can kind of have a drum roll. Using these criteria and specifically the 50,000 population criterion, the only areas that met the 50,000 population really were the

area west of Alpena, and that kind of long, snaky area which is in the Upper Peninsula. And I think that that last requirement that I outlined, that in a rural area 50,000 people need to be within a 60-minute travel time of the proposed location of a new hospital, will limit the places in the Upper Peninsula where a hospital really could be placed. Those of you who are familiar with the Upper Peninsula realize that there are probably more squirrels, chipmunks and deer up there than there are people, and a lot of those shaded areas are really national forests so that in the Lower Peninsula, the only area that qualifies as a limited access area is Alpena. And, Stan, correct me if I'm wrong, I think that the bed need for that area is 137 beds.

MR. NASH: Correct.

MR. MEEKER: So that's the discussion, then, of the limited access area. Well, I shouldn't say that. There are other requirements. Since this description is for an exception to the bed need methodology, we felt as though additional requirements could be placed on hospitals who applied for this exception because by the traditional means, of course, there is no defined need for these hospitals, but we're defining it in terms of access. First of all, we felt that these -- the hospitals that applied for this exception would have to meet certain additional requirements. In addition to the bed size, they would have to, of course, provide acute care -- acute inpatient care; they would have to provide surgery; they would have to provide obstetric services; and they would also have to have a 24-hour emergency department. Furthermore, we felt that these needed to be full-service hospitals, and we were not looking for the opportunity for there to be specialty or even tertiary care hospitals to be established in these areas, so that for at least the first five years after they begin operation, they needed to have basic community hospital services and would be prohibited from having CON approval for open heart surgery, therapeutic cardiac cath -- and that would not include, of course, primary angioplasty -- a fixed PET scanner, although mobile PET would be appropriate; a neo-natal intensive care unit; a fixed lithotripter, or any transplant services. We also felt that hospitals created under this exception should be prohibited from relocating their beds for at least 10 years after beginning operation. These hospitals were established to meet a specific need based on travel time and access need, and so there are provisions throughout the standards and in the law that allow relocation of beds. Hospitals created under this exception should not be allowed to take advantage of those provisions for at least a period of 10 years. So that's kind of the underlying rationale of the portion of the recommendations dealing with access defined as travel time. And we have developed what we're calling "limited access areas," which would qualify for additional hospitals.

MR. STEIGER: Okay. We're going to have Maureen Halligan run through the high-occupancy issue.

MS. HALLIGAN: Good morning. I'm Maureen Halligan, with Genesys Health System. I was part of the SAC and will be talking to you this morning about the high-occupancy exception. High occupancy, for those of you who have been around a few years, you will remember that that was pilot language that was included in the hospital beds standard. That language was approved as only a pilot; it expired a year ago in November. Under the pilot program, hospitals that had less than 300 beds that ran at 80 percent occupancy or greater for an extended period of time would be able to add beds to reduced their occupancy down to 75 percent. Likewise, hospitals that were over 300 beds were held to a little bit higher standard of 85 percent, recognizing that because they had more beds, they might have a little more flexibility. But after they had proven a track record of running at 85 percent or more occupancy, they would be able to add beds to bring that occupancy down to 80 percent. Under that pilot language, two applications were approved; one for a hospital under 300 beds, the other for a hospital over 300 beds. And a total of 122 beds were added to those two hospitals. As we thought about that high-occupancy exception, we felt there were pros and cons and we considered those as we went through our deliberations. For one thing, the bed need methodology as it currently exists does not address access to high-occupancy hospitals, even though they may be in over-bedded areas. Those hospitals are still very full. You can hear stories of people waiting for a long time in the emergency room or waiting a long time for beds. So we felt that we weren't providing adequate access to those patients who chose those hospitals, even though they were in over-bedded areas. We felt like we needed to meet that consumer demand. But on the other hand, we heard comments from hospitals about the potential negative impact that might have on other hospitals in the area who were not full. And we recognized that in certain areas, we were -- had the potential to increase the over-bedded situation. As Mr. Steiger said earlier, high occupancy was part of our charge. We heard testimony from a number of organizations, both for and against that high-occupancy exception. We also, toward the end of our deliberations, heard some testimony from hospitals with very high pediatric populations or separately

licensed pediatric hospitals asking us to recognize the volatility and the seasonality of pediatric populations and suggested that perhaps their target occupancy should be lower for them to qualify for the high-occupancy exception. We concluded at the end of our deliberations that the high-occupancy exception had merit, but hospitals that were operating at a very high level of occupancy were, indeed, providing inadequate access to their patients and should be able to provide a reasonable level of access to care. But we felt that because the state was overbedded, ideally, those additional high-occupancy beds would come from other hospitals that perhaps weren't utilizing the beds; they were not operational. We recognize that that's not always feasible. We also wanted to make sure that if hospitals were transferring beds from one to another to meet those high-occupancy hospitals' needs that we didn't, as a consequence, create a bed need in another area of the health service area. So we wanted to be cognizant of not robbing Peter to pay Paul, if you will. So we asked that high-occupancy hospitals make a good faith effort to solicit beds within the health service area without pulling one of the sub-areas under the bed need minimum. We also considered a proposal that would have required the Department to de-license beds that were not utilized, recognizing with this high-occupancy exception that maybe we're removing the incentive that many hospitals have to hold onto their beds, because once you give them up you can never get them back. Here we were opening a door so that hospitals would be able to add beds as they were required. But what we found was that it was not clear whether or not the Department had the legal authority to require hospitals to de-license beds that were not operational. And one of our recommendations is that the Department use some additional time to investigate whether or not it has the legal authority to de-license unused or mothballed hospital beds. So our recommendations are that this pilot language for high-occupancy hospitals be included as a permanent part of the hospital beds standards. But the beds for high-occupancy hospitals obviously have to be added at the current site. Sticking with the original language, hospitals under 300 beds would have to meet a target rate of 80 percent or higher occupancy, and would be able to add sufficient beds to bring that down to 75 percent occupancy. Likewise, hospitals over 300 beds would be able to add beds over 85 percent -- would be able to add beds to bring their occupancy down to 80 percent. We wanted to eliminate any potential for sort of gaming the system, if you will; that is, hospitals solicit unused beds from other hospitals. We need to recognize that if you give up hospital beds at your location to another hospital, you will not be eligible to apply for the high-occupancy exemption for five years. We didn't want to create a market for selling hospital beds and then, you know, you would take yourself down to that high-occupancy level and then add beds and sort of create a cycle that way. So hospitals that transfer beds will not be able to apply for the high-occupancy exception for five years after the relocation. And then next time the standards are reviewed, we would ask that the next SAC take a look at that high- occupancy exception for pediatric and other specialty services. It came to us sort of towards the end of our six months. We felt like the issue had merit. We didn't have sufficient time to address it and really consider it. But we would like the next SAC, as this work goes on, to really consider the issue of pediatric and other special populations on the occupancy exception. With that, I'm going to turn it over to Peg Reihmer and comparative review language.

MS. REIHMER: Good morning. I'm Peg Reihmer from Botsford Hospital. And I had the privilege, actually, of chairing a workgroup that -- whose charge was to develop criteria to distinguish amongst competing applicants in an instance where a limited access area was identified, presuming that there would be or could be multiple applicants to fulfill this stated bed need. We operated with three decision rules. One was, does the criteria effectively distinguish amongst applicants, is it measurable, and do we have a verifiable, independent source for the data that would be used to evaluate the criteria. The workgroup looked at 13 different areas to consider establishing comparative review criteria. You can see them there. I'm not going to go through all of them, but we did have extensive discussion about virtually every one of those. And our conclusion was that we should establish six criteria that needs to be kept to a manageable level. And there was a fair concurrence on what those six should be and the number of points allocated to each, given a 100-point scale. First was the percentage of uncompensated care that the applicant has provided; similarly their percentage of Medicaid participation; whether, in fact -- a proposed reduction in inpatient capacity elsewhere; what their existing market share in that limited access area was and had been historically; and what percentage of the population their site would cover within a 30-minute travel time; and then finally the capital costs per bed. We did propose specific language which will be reviewed at the same time the other language is reviewed. That's it for my workgroup.

MR. ASMUSSEN: Good morning. I'm Bob Asmussen, St. John Health, and a member of the SAC to talk about the items that we consider important for continued work by the Commission and particularly, perhaps, through a SAC, although Public Act 619 provides you latitude to get these things done other than by

appointing a SAC. Three of the four recommendations actually are related to recommendations before you today. The fourth is a stand-alone. The first relates to the 30-minute time rule that would impact limited access areas. The current recommendation before you in effect identifies limited access areas within 30 minutes of a hospital -- singular, "hospital." We don't know, particularly in the highly populated areas of the state, whether there are adequate number of beds to serve the population of those areas. So the recommendation -- the additional recommendation before you is that you add to the work plan work that presumably would be done by the M.S.U. Department of Geography to help us to understand whether, in fact, we have additional limited access areas within the state where there are inadequate numbers of hospital beds. And just as an example, given the shift in population in Oakland County, you have one institution licensed at 153 beds on the western side of that county. What we don't know is whether -- if you filled that hospital, whether some residents within that part of the county are adequately served by the number of beds available. The second recommendation relates to the high occupancy provision that's been recommended to you. And as Maureen Halligan indicated, towards the end of our work there, we began talking about specialty care units, their impact on the availability of what we typically would call our most used beds, the med-surg category. And pediatrics was significantly discussed, but there are also other specialty units, typically in larger institutions, that experience significant fluctuations in occupancy and serve in the down time, if you will, to reduce their average occupancy. And so what we don't know is if you applied that kind of criteria, would you find, in a given week, that the med- surg beds of that institutions are at 100 percent. So we thought additional work could be done in that category. The third relates, again, to the limited access areas, and to the issue of comparative review criteria. Frankly, the SAC was very proud of its work in this area, and think that for all intents and purposes, the comparative review criteria developed for limited access areas could also be applied to proposals for additional beds that are not in the limited access area. And we got to about 90 percent agreement, I would submit to you, when the clock ran out on us. And so we didn't have the opportunity to flesh out a few of the significant questions that related to a couple of the criteria, but think that we're pretty close. And one of the Commission's concern over time is the lack of comparative review criteria. So some additional work there, I think, would allow us to finish that recommendation as it relates to all applications for Certificate of Need. And the fourth and last is a stand-alone concern that has been around for a significant period of time, and that is to incorporate consideration of access by public transportation, racial and ethnic diversity, cultural competency, sensitivity of language barriers and the project delivery requirements for all covered services. The current standards lack definition in this regard. So we -- if -- to the extent the Commission agrees, clearly this can be an assignment on your work plan that could be undertaken in the next period. And, Dale, I think it's back to you for questions or whatever.

MR. STEIGER: I believe that concludes our report.

MS. TURNER-BAILEY: I want to thank you, Mr. Steiger and the rest of the members of the committee, for that informative and thorough report. At this time I would like to know if there are any questions from the commissioners. Yes, Commissioner Andrzejewski?

MR. ANDRZEJEWSKI: I have a question for Mr. Meeker. Bob, did you do an incremental assessment of the limited access areas, plotting out the map and how it changes at five-minute intervals, say to determine the scope of the problem in some of these limited access areas that are primarily in northern Michigan? I mean, for example, if the criteria were 35 minutes, does the map change significantly? If it were 40 minutes, does it change significantly?

MR. MEEKER: I'm going to ask Dr. Messina to opine on that. But before I do, as I said, we attempted to be very objective and detached and not try to predispose whatever the decisions were going to be. And so we set the 30- minute criterion before we did any maps. And there were some people who thought that that criterion should be a lot larger; that it should be a lot more than 30 minutes. There were other people that thought it should be considerably less, so that the criterion was the result of a compromise, as far as what was an appropriate measure of access. Certainly there is the capability of doing what you said, and Dr. Messina may be able to at least give an intelligent response to that. It was not something we did in great detail though.

MR. MESSINA: Hi. I'm Joe Messina from the Department of Geography. In answering the question, when we calculated the model, we actually calculated very specifically down to the minute for every square

kilometer for the entire state. So we do have the information regarding the changes at 35 minutes, 40 minutes, 45 minutes. So it's actually the amount of time per square kilometer to the nearest hospital, regardless of its actual direct, straight-line distance. So it is an actual time to it. But the way the Commission asked us or charged us to establish this criteria, we cut it off at 30 minutes very precisely.

MS. TURNER-BAILEY: Any other questions? Commissioner Sandler?

DR. SANDLER: Yes. I have a number of -- not specifically to you. If there's any questions for them, I apologize. I have for -- some questions and some comments. We would like to commend the staff for the great deal of work it's done. We always appreciate them. In the limited access hospitals, I have several comments. First, I question the need for it to offer obstetrics. My comment on that would be -- I won't get on a soapbox from a medical society, but obstetrics is a big issue in the United States because of medical reform liability issues, finding people willing to do obstetrics, having an older age population in some of those areas; there are criteria I believe set by the State of the number of deliveries to offer that service. I think you could do -- a hospital performing surgery and the 24-hour emergency room, med-surg could still be a very significant improvement to a community even if it didn't offer obstetrics. So I would question that. Second question are the five tertiary things. I think in sparsely populated areas, it would be unlikely that they would want to or could have that patient population. I would question whether this Commission, however, should interfere with the laws of supply and demand. But our -- we've set criteria and CON for each one of those. If they can fulfill the criteria that we've already established for that why are we preventing them from getting something? It's inconceivable to me, for example, that any of them could have a fixed PET unit. But we have criteria for fixed PET units. And if they can fulfill that criteria, why would we discriminate against them would be my point, since we do have CON criteria for all of them? On the 80 -- on the high occupancy my question is, are we talking about only med-surg beds? Some of these institutions have psychiatric beds that may not be 80 or 85 percent. But it wouldn't help you if patients lying in the emergency room have med-surg issues. Are we talking about all beds? Only med-surg beds? Pediatric beds? Obstetrical beds? What were that 80 or 85 percent occupancy? Was it all beds?

MR. MEEKER: Not psych.

DR. SANDLER: Only med-surg beds?

MR. MEEKER: All acute care beds, not psych beds.

DR. SANDLER: Okay. I would question, again -- the beds can either -- I need some help on this. Are there beds that only can be used for obstetrics in hospitals, they cannot be used for med-surg?

MR. MEEKER: No.

DR. SANDLER: They're -- the only beds that cannot be used are psychiatric beds or peds beds?

DR. YOUNG: Only psychiatric.

DR. SANDLER: Only psychiatric?

MR. MEEKER: Yes.

DR. SANDLER: Although the practicality is that in a peds ward you don't put an adult who's had -- would have had an MI. But I would just question these -- I would question peds being part of the occupancy. And perhaps it would be good with some staff -- the LAA comparative review process, the material looked fine. But my question is -- I was confused -- do you mean the criteria of projecting whether 25 percent would be uncompensated, since this would be a new hospital? I'm missing this point.

MS. REIHMER: We can get into the specific language, but it applies actually to the -- and I will use this as a general term because the 619's got funny language that is very specific -- but to the sponsoring organization's history of providing uncompensated care or Medicaid services, not to the projected volume of care that they will be providing.

DR. SANDLER: What if the sponsoring organization really doesn't have much of a track record, however?

MS. REIHMER: Then I guess --

DR. SANDLER: They could be from another state and --

MS. REIHMER: That's correct; in which case they would get no points.

DR. SANDLER: Perhaps we'd need a little bit more input to level the playing field. It's not a major point --

MS. TURNER-BAILEY: Were those rhetorical questions? Or do you want somebody to come up and answer?

DR. SANDLER: Well, no. I got a good answer.

MS. TURNER-BAILEY: Okay.

DR. SANDLER: It's not clear to me that's the best -- I mean, it's a good answer. But my concern would be are there loose ends that perhaps we need to tighten up, --

MS. TURNER-BAILEY: Okay. Thank you.

DR. SANDLER: -- which could happen.

MS. TURNER-BAILEY: Commissioner Hagenow?

MS. HAGENOW: I just wanted to make one comment, and then I do have a question. I am extraordinarily pleased. I felt that this may just be a "take the exception, try to find the rule to make it happen." And you took a much higher level of "What is access?" and went to what I would consider to be health policy standards in looking for something that I could tell other people, "Here's what the standard is and why it is." And so that just -- I think is very, very exceptional. So my kudos to everybody. From my perspective it met what I was looking for and it wasn't just a political animal trying to find a reason for the exceptions. The question is, how critical is the next SAC, that -- basically what I see is that you've identified in health policy language what the access issue -- what would be defined as something we can articulate very clearly as what's required in a distance and time to get access in to the hospital, but nothing that -- other than sort of bare bones that's there as to what the capacity of that hospital needs to be. And so how critical is that in timing to be moving on so that this Commission continues to be moving and shaping in a very positive and rapid sort of a way?

MR. STEIGER: Now, as I think we both said, these were issues that, in most cases, came up toward the end of the process. There is not unanimous agreement as to whether we would adopt all of these things or not. But we felt in order to operate an honest process, which was -- our primary objective was to operate an honest process -- that in order to do that with some of these issues that came up late, that we needed someone -- I hate to use the word "we" -- that some group next year needed to continue the work here and to see, basically, if there needed to be some adjustments or revisions. We feel that what we've recommended stands on its own, and that it meets the spirit and the letter of the charge. We just felt that in order to run a continuing honest process that we should take another look at -- that someone should take another look and see if revisions need to be made. Do you want to add anything to that, Bob?

MR. MEEKER: I think that one of the things that I did not mention is that there were at least three major approaches that the workgroup looked at in looking at access. One was completely redefining the whole sub-area structure, and that, of course, was one of the two major sets of recommendations that the Commission approved a year ago. Quite frankly, the -- I would have to say that the majority of the workgroup felt that the sub-areas -- or the sub-area process was well defined, had a lot of support -- methodologic support behind it, and that was not something that we wanted to do. The limited access area

thing that we've just described was a second approach. And the third was, as Bob said, the third was saying, "Well, okay. So there are a million people within 30 minutes of a 100-bed hospital," --

MS. HAGENOW: Right; the capacity of that hospital.

MR. MEEKER: -- is that good access? And, you know, I think to varying degrees, people thought that that was a valuable question. It was not one that we could answer within the period of time. I do think it's safe to say that some members of the SAC approved the limited access language with the understanding that we would be recommending going forward. We've had conversations with the geographers at M.S.U. I think it's a project that they're very interested in. It's also one that they can't undertake until next summer. So I think it would be a valuable direction of inquiry and, again, without any preconceived notions of what it comes out with, there may, in fact, be additional -- we might have to call them something different than limited access areas, but other areas that really don't have sufficient access to hospitals -- existing hospitals.

MR. ASMUSSEN: I would just add to that comment along these lines: that for those of you who have looked at this recommendation, you obviously don't see any potential solution on the table for southeast Michigan. The green areas, as they were on our maps, are all in rural areas. And so what did we accomplish? Well, part of our difficulty was when working with M.S.U. we were a little unclear as to what we were getting. So at a point in time when -- we got interested in, "Well, what about the population by these kilometer breakdowns?" And it turned out that we were asking for information that had not been calculated by the university and that it would take additional time to draw those sorts of calculations and tie that availability with population bases. And so they've committed to do that, should they be re-engaged to do that piece of it. So that's why it was so significant that we add that component to it. So it's not that we were avoiding the major issues before the group, but the fact of the matter was we just didn't have the time, with their schedules, to examine that question and come up with a more complete answer to that question.

MS. TURNER-BAILEY: Commissioner Goldman?

MR. GOLDMAN: I just had one question. And I want to just echo what the other commissioners have said about the very nice work that you've done. On the high-occupancy exception, there is a stipulation that high-occupancy hospitals acquire beds currently licensed whenever possible. What was your thought process about how you would operationalize "whenever possible"? I'm just concerned about gamesmanship in transferring beds from one hospital. I understand the stipulation and I agree with the stipulation about transferring beds so you create high occupancy in another facility. But I just wanted to hear more about what you thought "whenever possible" would mean.

MR. STEIGER: Well, I believe -- and keep in mind, I don't know any details or anything, I just basically kept track of people at these meetings. But essentially, we were concerned that -- and there were members of the SAC that were concerned that implementing a high occupancy proposal essentially would add beds to the inventory, which as we all know and we should all remember, is significantly over-bedded at this point. So we felt that one way to minimize the over-bedding or to keep it where it is was to ask the high-occupancy hospital that would be getting the advantage of additional beds to make a good faith effort to work with some other hospital to try and acquire -- to transfer, basically -- buy, transfer, what have you, those beds so that we would minimize or negate any increase in the bed inventory.

MR. GOLDMAN: I guess my concern is what you just said, the "buy or transfer." I don't want, for public policy reasons, to create a state law that allows a hospital to sell beds at a premium.

MR. STEIGER: Well, I think that's why the language is in there, "whenever possible." We had significant discussion on that, and we've had discussion with folks that have gone through that particular effort. And the language "whenever possible" is in there so that the high occupancy applicant would have the opportunity or the ability to say "no," and those beds then would be added to the inventory. So it would have to be a fair transaction in order for it to take place.

MR. GOLDMAN: So "whenever possible" would mean "whenever possible at fair market rates," whatever that is? I mean, it always possible -- I would be happy to sell you this valuable cup for a million dollars. It is possible to do that transaction; not a good idea.

MR. STEIGER: Correct.

MR. GOLDMAN: And that's my concern. I just don't want language that is vague enough as "whenever possible," because that would create an economic -- an unfair economic market.

MR. STEIGER: Maureen, do you want to add anything to that?

MS. HALLIGAN: It is an issue that we struggled with. The other side that we looked at is that smaller hospitals that may have unused beds might benefit from an infusion of capital and be able to do some other things in their community. So we did look at it as a win/win. As I think about the CON standards, the Department, when we do various CON-covered projects, asks us to demonstrate that it's the lowest cost alternative. So there is that check and balance, I think, on the price of beds. We also, you know, heard some testimony that there would be a little bit of demand and supply dynamic, if you will, because you might have beds and you might have beds and you might have beds. And so as we solicit beds, the price -- you wouldn't buy the most exorbitant beds so that that might help moderate it. The way that we would expect people to demonstrate this good faith effort is simply to show that they sent a certified letter. So we're not expecting that people who want to add beds would spend a million dollars a bed or, you know, whatever. So we tried to build in some checks and balances, and tried to create a win/win situation for smaller hospitals that might have beds to use, but, again, might benefit from some infusion of capital.

MS. TURNER-BAILEY: Commissioner Deremo?

MS. DEREMO: Mr. Steiger and Mr. Meeker, I think that you and your staff's work falls in the "no good deed goes unpunished" category, and I want to commend you for your exceptional work. I did have a question, Mr. Steiger. In relationship to -- and you might be able to help me with this -- it looks like the SAC followed the charge, but did a couple of things that were not within the specific charge of the Commission and then did not have enough time to complete part of the charge -- the complete charge from the Commission. Am I understanding that correctly?

MR. STEIGER: I don't think so. We felt that we stuck to the charge pretty religiously with the exception of making the recommendations for future work. But even those recommendations were made in the context of accessibility and access to hospital beds. So we don't think that we went beyond the charge in any fashion. I mean, if you have specific -- do you have a specific –

MS. DEREMO: I just -- in looking at some of the -- at the e-mail that you sent, you said, "We actually had gone beyond the charge given to us" and then included additional work. So I was a little confused by that.

MR. STEIGER: I think what I meant at that particular point in time -- and basically that's sort of marginally correct -- is that we took the opportunity, because we felt it was within the charge, to do the comparative review criteria. And that was raised as part of the discussions of the SAC. We went back to the chair and the co-chair just to confirm the fact that that, in fact, was part of the charge because we have to have that criteria in order to approve an applicant.

MS. DEREMO: Thank you.

MS. TURNER-BAILEY: Commissioner Andrzejewski?

MR. ANDRZEJEWSKI: Maureen, you talked about the privilege of adding hospital beds in over-bedded sub-areas, providing the hospital was able to demonstrate sustained high occupancy. What does "sustained" mean?
MS. HALLIGAN: I may have to defer to Brenda on this. I'm going to look for you for confirmation. I believe it's 12 months. Is that correct?

MS. ROGERS: That's correct.

MS. HALLIGAN: So if we were to --

MR. ANDRZEJEWSKI: Rolling average?

MS. ROGERS: Previous 12 months, prior to.

MS. HALLIGAN: Typically we're asked for the most recent 12 months. So if we were to operate at 85 percent occupancy for a 12-month period, then we would be able to add beds to bring that down to 80 percent, and likewise for a smaller institution.

MS. TURNER-BAILEY: Are there any further questions? Commissioner Maitland?

MR. MAITLAND: That part of your recommendations where you're limiting certain services -- and Dr. Sandler alluded to that -- I assume that you did discuss, when you were working on this section, the fact that you would be overriding existing standards and criteria for those standards, in the five-year limit?

MR. MEEKER: I think our point here was that these hospitals in limited access areas represent exceptions to the bed need methodology. By the "bed need methodology," these aren't needed hospitals, they're part of the additional criterion of access measured by travel time they are. So in those circumstances, since it is an exception, certainly the workgroup felt -- and I believe that the SAC agreed with us -- that we could put additional restrictions on those particular applicants. The aim was that these would be community hospitals. And I agree with Dr. Sandler to the point that it's very unlikely that anybody would apply for these services. But we wanted to make it very clear that these are to be community hospitals, they're not to be tertiary care hospitals. And it's only a restriction for five years; it's not in perpetuity. So for the first five years of their existence, they need to concentrate on being good community hospitals in providing service to the people in the limited access area. That's the intent.

MS. TURNER-BAILEY: Commissioner Sandler?

DR. SANDLER: I don't want to beat a dead horse on this one, but my comment would be as follows: That I think it's unlikely any of these institutions would apply for this. But we do have standards that they do apply, that their community needs one of these things and can meet the standards, I don't think we should discriminate against them. I think it's unlikely to occur, but if it does occur, if they can meet the CON standards, the community needs it, that's where the law of supply and demand comes in, I would not be opposed to simply letting them have it.

MR. MEEKER: It was the judgment of the SAC that we should make that discrimination.

MS. TURNER-BAILEY: Any further questions? (No verbal response)

MS. TURNER-BAILEY: Thank you. Brenda, did you want to make a comment?

MS. ROGERS: (Shaking head negatively)

MS. TURNER-BAILEY: Okay. I have some cards. Roy Sexton?

MR. SEXTON: Good morning. My name is Roy Sexton, I'm the director of corporate planning at Oakwood Health Care. Oakwood operates four inpatient hospitals with 1,307 inpatient hospital beds in west and southwest Wayne County, and offers a wide array of hospital outpatient diagnostic, physician and other medical services. Oakwood supports appointment of a new hospital bed Standard Advisory Committee to resolve additional issues related to the number and distribution of hospital beds in Michigan. Consistent with its obligations under the Public Health Code, we also urge the Commission to ensure that the charge to the Standard Advisory Committee include review of the current replacement zone for existing licensed hospital beds. Although the prior SAC considered the current replacement zone, we do not believe that there was sufficient discussion of this issue with presentation and consideration of specific issues. Currently of the four hospitals operated by Oakwood, three hospitals are located in buildings that are 45 years or older. Although we continue to maintain and improve these facilities, we anticipate that at some point in the reasonably near future, it may be more cost-effective for Oakwood to simply replace one or more of its existing hospitals to a

new physical plant. With the other pressing issues for the SAC and number of issues assigned to it, we believe further discussion of this issue would be appropriate, particularly to address situations where land is not reasonably available within a two-mile radius of the current facility. We support the CON program's determination of hospital bed need on a planning area basis. We also support reasonable restrictions on the replacement zone to assure that hospitals continue to serve the populations where they are currently located. However, given the current review of other aspects of the hospital bed standards, we believe that it would be prudent and consistent with its obligations under the Public Health Code, and specifically Public Act 619, for the Commission to request a new HBSAC to re-examine this issue. The Commission, Department, providers, payers and the citizens of Michigan would be well-served by a comprehensive approach to hospital bed planning, which includes a review of current restrictions on replacement of existing hospital facilities. We urge the Commission to amend the charge to the HBSAC to include a review and determination as to whether the current hospital bed replacement zone is appropriate. Thank you.

MS. TURNER-BAILEY: Any questions? Commissioner Andrzejewski?

MR. ANDRZEJEWSKI: Do you have any recommendation on the size of the replacement zone?

MR. SEXTON: No; not at this time, but -- our primary recommendation being that the group needs to return to that question and have thorough deliberations consistent with the other discussions they've had so far.

MS. TURNER-BAILEY: Commissioner Hagenow?

MS. HAGENOW: If one has access by time and if we charge the second part, which is the capacity that must be there, then why revisit the -- where the lines are drawn?

MR. SEXTON: Well, I think the primary point we're trying to make is that that question maybe hasn't been completely answered to the satisfaction of everyone that was part of that group; that those two pieces are significant, but that we have not yet considered what are the ramifications for not considering the other.

MS. HAGENOW: Okay.

MS. TURNER-BAILEY: Any other questions? (No verbal response)

MS. TURNER-BAILEY: Thank you.

MR. SEXTON: Thank you for your time.

MS. TURNER-BAILEY: Yes, Mr. Steiger?

MR. STEIGER: I would just like to point out to the Commission that Oakwood had a representative on the SAC and there were essentially very little comments -- probably no comment -- I don't have the minutes, but it was never a proposal, never any significant discussion from that particular organization. (Off the record interruption)

MS. TURNER-BAILEY: Fran Dalton?

MS. DALTON: Good morning. I'm Frances Dalton. I'm a volunteer member of the Alliance for Health planning board. I'm a member of the Board of Directors of the Grand Rapids African-American Health Institute, and of Healthy Kent 2010. I'm also a community corrections coordinator for the County of Kent. It is a pleasure to be able to address you today about a very serious issue. In December 2003, the Alliance for Health directed its president, Lody Zwarensteyn, to present to you several considerations that we believe are especially important for use in distinguishing among proposals that are seeking Certificate of Need approval. Recently we brought these to the attention of a workgroup of the Standards Advisory Committee that was considering revisions to the standards for acute care hospital beds. The workgroup suggested that the most appropriate location for our recommendations would be in the Certificate of Need project delivery requirements rather than in comparative review standards because they address actions that all applicants should take, not just those who would like extra points to place them ahead of other applicants in the

comparative review. The Standards Advisory group has included recognition of these recommendations in its report to you. We urge you to add these to the project delivery requirements for proposals seeking CON approval. The Alliance for Health asks the Certificate of Need Commission to include provisions in the standards for acute care hospital beds, as well as standards for other covered facilities, services, and equipment, to assure that applicants very seriously address issues of health-related disparities in our population. By most measures, there are major disparities in health status based on race, ethnicity and income. Similarly, there is significant evidence that the cultural competence of caregivers has a direct effect on health. Avoidable disparities must be addressed by all of us if they are to be overcome. To that end, we believe that the standards should urge project sponsors to demonstrate that they are aware of these issues and will actively do something about them. As a matter of public policy, the standards should urge project sponsors to assure that they will act in their own appropriate way to deal with disparities as well as the acceptability of their care. Recent reports of the Institute of Medicine, the Sullivan Commission and Michigan's Surgeon General directly address disparities. The State of Michigan even has announced a grant program for providers to address disparities. If all are doing their part, there would be no need for such grant programs, but their existence demonstrates the need for the Certificate of Need Commission to help by doing its part to encourage health care providers to appropriately address disparities in their own way. In 2003, the Institute of Medicine reported on disparities between minority and white patients, and it called for greater workforce diversity in the health care system and an emphasis on improving all medical workers' cultural sensitivity in response to changing demographics. The Institute of Medicine suggested that health care professionals' stereotypes, bias and uncertainty may contribute to gaps in the quality of care between minority and non-minority patients. The evidence is clear, cardiac care, hypertension, infant health, renal disease, diabetes, black patients are less likely to receive essential care than whites. Similar disparities exist for other minorities, and there are many reports of similar concerns among immigrant populations. The Sullivan Commission on Diversity in the Health care Workforce report, "Missing Persons: Minorities in the Health Professions, 2004," highlighted the disparity between the ethnic makeup of patient populations and that of health care providers. It concluded that a lack of diversity in clinics and hospitals can make medical care uncomfortable, frustrating or inaccessible for too many immigrants and minorities, and that this comes at a cost to patients' health. The disparities in health care of our population create a situation that costs all of us and begs for solutions. A workforce hindered by untreated or poorly treated disease or injury adds to our medical expenses by raising insurance premiums and increasing the burden of the state's taxpayer-paid medical services. Recently Michigan's Surgeon General recognized this in issuing her prescription for Michigan's health. This prescription called for attention to the disparities in health among Michigan residents. Clearly the Michigan Department of Community Health has recognized this by making grants available for entities to help reduce disparities in health status. Had the right thing been practiced as a rule, there would not have been a need for such grants. We believe that wherever appropriate, the state's policies, including Certificate of Need requirements, should be consistent and supportive of our Surgeon General's prescription and of reducing the existing disparities. Below are the thoughts that we urge you to add to the project delivery requirements for proposals seeking CON approval. We sincerely believe that such requirements will help create greater value in our health care system, and we urge the CON Commission to act to adopt these considerations. Our recommendations encompass six areas. In the case of construction of new facilities, physical access to the proposed services should be assured, including means of public transportation such as locations on public bus routes. Public transportation is especially important to lower income patients and to lower-wage-earning employees who do not have independent means of transportation. Lack of available public transportation can fuel the forces that create disparities in health status among different groups in our population. If services are to be relocated, there should be an assurance that there will be no lessening of accessible services for populations left behind. To avoid adverse consequences of providers relocating services primarily to be closer to markets with a richer payer mix, and abandoning those with fewer resources, reasonable provisions should be required to maintain services for the people left behind. Reduction of clearly excess capacity need not be affected by such a requirement, but reduction of capacity that is clearly needed and is being utilized is a threat to the well being of the people currently being served. Project sponsors should commit to arrange for qualified and culturally aware translation services to address the range of languages spoken in their proposed service areas at a minimum. Also, translation services must go beyond having relatively unskilled workers available to translate complex medical terminology. Project sponsors also should commit to arrange for staff training in cultural competence as would apply to the target populations. The ability to communicate with and understand patients is essential to quality patient care. We have many patients from many backgrounds. It is important that each project sponsor assure that it is working to be as relevant to its own service population as possible. Further, it is important that

translation be conducted in a manner as to recognize cultural factors and thereby assure the flow of appropriate information between patient and caregiver. Project sponsors should be required to make good faith commitments to strive to have their support, administrative and professional staff reflect the racial and ethnic makeup of the entire area they propose to serve. The State of Michigan clearly should promote reasonable efforts by providers in this regard. We understand that the current supply of personnel may not adequately provide for an appropriately diversified workforce at this time, but reasonable efforts must be encouraged to have the workforce resemble the population it purports to serve. Project sponsors should commit to arrange and/or participate in periodic programs for their staff, patients and communities that address racism and its effects on health care. Racism is an ugly scar with numerous effects on the health of our population. Often services are delivered by individuals who are unaware of behaviors that emanate from a racist heritage, and awareness of such behaviors is important if we are to work to serve all effectively. As an active community volunteer, I can attest that our recommendations are realistic and needed. We can address disparities meaningfully if each of us does our part. Thank you for your attention.

MS. TURNER-BAILEY: Any questions? Commissioner Goldman?

MR. GOLDMAN: Thank you for that. The SAC that just submitted their recommendations to us indicated that the next group should incorporate considerations of access by public transportation, racial and ethnic diversity, cultural competency and sensitivity to language barriers in the project delivery requirements for all covered services. I think -- but correct me if I'm wrong -- that that covers what you were discussing, with the possible exception of the relocation issue, --

MS. DALTON: The Alliance for Health --

MR. GOLDMAN: -- if relocation and access to the populations left behind. Is that right?

MS. DALTON: That's correct. The Alliance for Health is very supportive of that recommendation.

MR. GOLDMAN: Thank you.

MS. TURNER-BAILEY: Any further questions? (No verbal response)

MS. TURNER-BAILEY: Thank you. David Kaser? (Off the record interruption)

MS. TURNER-BAILEY: As Mr. Kaser comes forward, I'd just like to remind you of my request for a three-minute limit on your comments. I'd very much appreciate your cooperation in that regard. Thank you. (Off the record interruption)

MR. KASER: I'm from Miller Canfield, and I'm here on behalf of Covenant Health Care, which is based in -- which is in Saginaw. It is the combination of the St. Luke's and Saginaw General merger a number of years ago. And the only message they asked me to deliver, well within a three- minute limit, is that they have been watching the process and have been enormously gratified by its success and the route it has taken, and wholly endorse the future SAC study and will certainly contribute anything this Commission might want from Covenant toward that end. So in terms of the future SAC study, put Covenant in the "we favor it" column. Thank you.

MS. TURNER-BAILEY: Thank you. Are there any questions? (No verbal response) (Off the record interruption)

MS. TURNER-BAILEY: Steven Scapelliti?

MR. SCAPELLITI: Good morning. I appreciate the opportunity to address the Commission this morning. I will do my best to stay within the three-minute limit. With respect to the issue of drive time, the services available at your destination once you arrive is a question which I believe the committee acknowledges has not been sufficiently addressed. It is an issue which was raised by Unity Health at the July meeting of the SAC committee. And we believe that absent consideration of what services are available, drive time is simply an insufficient means of determining whether need is being met. There are limited beds available,

especially in the City of Detroit. There was an October 4, 2004, article in the Detroit News where certain members -- representatives of certain members of persons represented on the committee, in fact, made the statement that there are insufficient beds in Detroit and around the southeast Michigan area. The reduced services in certain areas, that, again, is not addressed by drive time. "Drive time" doesn't say what happens when you arrive at an emergency room or a hospital. It hasn't been made evident in the presentation made today whether there was consideration for stoplights, traffic patterns, or whether it simply assumes, as it appears, that all persons have access to transportation. That is not the case. That certainly is not the case in Detroit or on the east side of Detroit, where up to a third of the persons do not have access to automobiles. Additionally, emergency rooms are not the only ways in which patients are admitted to a hospital. Drive time addressed simply the issue of access to an emergency room. Physicians are unable, many times, to get their patients scheduled for necessary surgeries simply because of a lack of available staffed beds in and around the city. Patients are transferred often to suburban hospitals when there are no room for the patients in the City of Detroit. St. John recently announced expansion of its services at its main campus, so it's something that certainly ought to be recognized and applauded. But this, too, demonstrates acknowledgment that there is a need within the city for additional capacity. The proposal also does not address the reality of the "medically underserved area" designation by the United States Department of Health and Human Services. The east side of Detroit has been under an MUA designation since 1994. It's been under an HPSA; that is "health provider shortage area"' designation, since 1994. This has not changed in the past 10 years. Over the past 10 years, as more than five or six hospitals on the east side of Detroit have closed, the situation has only gotten worse. More than 2,000 beds of the current inventories have been taken offline during that time. This is not addressed by the report. The designation has not changed, and the 30-minute drive time will not address it. The MUA criteria includes infant mortality rates, poverty levels, elderly population and physician-to-population ratios. These are used and calculated to come up with an MUA index, which is something that certainly ought to be considered if we're talking about access to health care. If the United States government considers it, it ought to be considered as well if criteria's going to be set with respect to bed standards. Unity Health, in particular, has concerns about the objectivity of the group, especially with respect to the recommendation that the Unity Health proposals not be acted upon. Several members of the SAC committee, prior to the meetings, strenuously opposed the Unity proposal prior to our appearance at the July SAC committee. We were asked to appear by the committee. We made a presentation on need, which was attacked, and, again, by many of the same organizations -- representatives of the same organizations who appear before this Commission and opposed the proposal. There's been no criteria offered for recommendation that the Detroit community does not require replacement of hospitals which have closed for economic reasons. We ask that the Commission take no action at this time with respect to the proposal; it be studied further. You should consider to allow public comment after sufficient notice. We have before us 31 pages, including a number of significant changes to the current acute care bed standards. Certainly the brief period of time we have today does not allow for sufficient analysis of it. It was revised, I see, just yesterday. When a proposal was made on June 15th, there was approximately one page for a change of bed standards to allow for Unity's proposal. The objections and public comment were that they had just gotten it and there wasn't enough time to analyze it. Certainly 31 pages warrants far more consideration and analysis than can be provided today, and certainly more than I can address in a three-minute limit. Additionally, Unity Hospital has changed and modified its plan. It incorporates many of the recommendations that are included for criteria for both the -- for high occupancy as well as the limited access area hospitals, including an emergency room within the first year. These ought to be addressed and considered by this Commission before taking action, particularly with respect to the Unity proposal. One additional item with respect to the high-occupancy proposal -- and this will be brief -- it serves only to concentrate market share in existing hospitals. It does nothing to promote competition; it does nothing to allow the expansion of hospitals through other organizations which are not currently operating hospitals. Thank you for your time.

MS. TURNER-BAILEY: Thank you. Are there any questions? (No verbal response)

MS. TURNER-BAILEY: Thank you. Robert Asmussen?

MR. ASMUSSEN: I am Robert Asmussen of St. John Health. I come now before you representing St. John Health, not the SAC, as such. Just a couple of background points and then the underlying -- what we believe needs additional work. The first is that the SAC came together with a majority of its membership concerned primarily about the fact that the State of Michigan is over-bedded, according to the bed need methodology,

and that adjustments to that methodology would not be in the best interest of the citizens of this state. As a result, there developed a significant minority of votes on the SAC that did not necessarily agree with the recommendations. And I would submit to you that those votes were from systems who operate significant numbers of beds in and around southeast Michigan. The concern we had was that the methodology selected, namely limited access areas, and its limitation to essentially rural markets based on that calculation, were not sufficient to respond to the basic issue before the Commission, and that is access to care in highly populated areas. And so St. John Health was interested principally, along with Ford and a couple of other systems, Oakwood among them, in looking at other methodologies rather than the 30-minute approach. We did not succeed in convincing a majority of the SAC to do that. So the fact that we had the first recommendation before you literally to add to the work plan an examination of this population extension of the 30-minute rule was critical to the votes. And we did vote for this with the understanding that this additional work would be done to hopefully answer some of the questions about access in the highly populated areas of the state. Secondly, and related to Oakwood's comments this morning, with all due respect to our Chair, St. John would agree with Oakwood that the opportunity to examine this question of the replacement zone -- the two-mile replacement zone did not get adequate air time to satisfy them nor us. Because as Ms. Hagenow said, she thought that this population piece might, in fact, resolve that issue. It does to the extent that the same system might want to build in a different location. But it could be -- and just to use Oakwood as an example -- that they would want to close two aged facilities in what was the old PCHA structure in western Wayne County, pick a new site that's not within two miles; that that possibility, without adding beds to the bed count in the state, would, in fact, be a significant advancement in terms of the care to people that reside in their service area. So we would agree that that issue needs additional work as well, although it did not make it out of the SAC as a recommendation. Any questions?

MS. TURNER-BAILEY: Any questions?

DR. SANDLER: My question is, to summarize your concerns about it, you believe there should be an additional SAC to address the issues you talked about?

MR. ASMUSSEN: Correct.

DR. SANDLER: And what is your perspective on the present SAC recommendations?

MR. ASMUSSEN: The present SAC recommendations are certainly worthy of adoption, recognizing their shortcomings.

DR. SANDLER: Thank you.

MS. TURNER-BAILEY: Any other questions? Thank you. Larry Horwitz?

MR. HORWITZ: Larry Horwitz of the Economic Alliance. I'm sure I'll be within the three minutes. I'm here to support the SAC recommendations and talk about the process and the outcome. Initially -- I mean, first of all, in terms of the composition, I think the Commission exercised good judgment. You're the ones who decided what the composition would be. I think the Commission exercised good judgment. There were clearly -- all the hospitals in southeast Michigan that want to build new hospitals somewhere else that are pushing very hard in the legislature and other -- they're all represented; Oakwood, St. John and Henry Ford. The hospitals that very much object to some of those proposals -- in fact, there is a lawsuit going on among them -- they were also represented on the committee; right? Not all of them, but some of them. But I think the Commission exercised good judgment that then there was another slug of hospitals, namely hospitals who aren't involved in this southeastern Michigan mural -- intramural fight at all. You put Genesys on, you put Spectrum on from Grand Rapids, you put Bronson on from Kalamazoo -- and I know I'm missing someone else in this exercise -- and then you had some people -- a statute requires to have different purchaser and consumer representatives; some that tended to be more allied with the people who want to break through the laws and some who tend to be otherwise. So it was a very good mix of people. Did some people come in with a perspective already? I daresay you couldn't meet the requirements of the statute, the two-thirds being knowledgeable experts, and have experts that have a blank mind with no perspective. I don't think experts can come that way. We recommend very much the proposals to you. Initially there was clearly a split within the group. There were those who wanted the drive time, and then Henry Ford and St.

John didn't like it, because as Mr. Asmussen said, it didn't produce the solution they would like in southeast Michigan so they wanted something else. What happened, though, I think was very good as I watched it. They ended up having a consensus and almost everybody voted for the package by stitching the two things together; go forth with the proposal that people had worked out and had specifics on for which we had data, and then recommend you a high priority to consider the other idea as a second phase, why that -- Henry Ford and St. John hadn't been able to put together the operationalization of how they would accomplish the concept of making sure that there not only is a hospital within 30 minutes, but enough beds within 30 minutes. It's a very complex issue of how you count -- you know, which hospitals do you count in calculating the number of beds in what area? What number of minutes are you calculating? It's not an easy task, and they hadn't been able to figure out how to do it. Finally, the M.S.U. people said, "Gee, we could do it" -- this is already about September when the Committee had already exhausted half of its -- more than half of its designated time. And they said, "But we're teaching now, kids are back, so we can do it next summer." That's really what's going on here. I think the other issues that began to come to the Committee beginning approximately September at the time of your last Commission meeting are the ones that are -- said, "Gee, we looked at this enough to say this should be the subject of further consideration, but we didn't have time enough." This Commission, by informal comment, told the SAC that, "If you're getting proposals halfway through, you have the responsibility of deciding on priorities." Well, they exercised it, but I think rather graciously said, "Well, we still have these other considerations and you should take them up later." There clearly are problems around the state, certainly in Detroit and otherwise. But the articles in the newspapers and everywhere else are articles that say there are not enough staffed beds. Staffed beds is not a function of the Commission or State government; staffed beds is a function of the hospitals. That Henry Ford does not have on certain days -- or other hospitals -- enough open beds, because they don't have enough staff, they don't have -- we still have a nursing shortage and other things -- that's -- you deal with the currency of licensed beds; they deal in the currency of whether or not we're going to staff all of the beds. It's a different question. You can keep on adding more and more licensed beds, that doesn't get you more staffed beds until we resolve the issues of nurses and auxiliary services and so forth. So I think it's a reasonably balanced program. When it finally got done, all these recommendations got approved by, I think, unanimity, but that may not be exact. I don't believe anybody ended up voting over the -- against the whole report. There may be elements of emphasis. But that's only by one or two on any given point. So I think they've done a miraculous job. I didn't think people could function this way in the six-month constraint imposed by the statute. There were more meetings per week per month of this committee than has ever occurred in the history of CON. I'm not sure you can get this much work out of unpaid volunteers. But it happened. So we would certainly recommend that, and certainly are quite committed to our people in a good faith effort to look at these other proposals, the -- take, for example, the St. John/Henry Ford one about how many beds. We want to look at that, see how it's operationalized and see if that, you know, deserves support. We recommend that you adopt that and, of course, when you do, this will go out to public comment. The number of pages you have before you of changes are eight pages that the Department has very nicely put together at the front, and there will be time for people to go out, study them carefully, come back at public comment at the public hearing, and then at your next meeting, to share with you whatever changes. But we'd urge you to go forth within the confines of the report before you and not use it as an occasion to add, you know, further topics. Thank you very much.

MS. TURNER-BAILEY: Any questions? (No verbal response)

MS. TURNER-BAILEY: Thank you. Any further discussion? Is there a motion? Yes, Brenda?

MS. ROGERS: This is Brenda Rogers. Just one comment. You were passed out a sheet this morning. It has an amendment, basically, from the Department. If you look at your language -- and I believe there were copies put out in the back for the public as well -- we would recommend -- and this is just to clarify and tighten up the high occupancy language -- at the end of Section 8(2)(b) in the proposed language before you, we would recommend adding -- the language that is currently there states, "The licensed acute care hospitals are located within the same HSA if the receiving hospital meets the requirements of Section 6(4)(b) of these standards." We would recommend adding the language, "And the relocation of beds shall not create a bed need in the subarea of the transferring hospital. So if you move this language forward today, we would recommend that you consider adding this one sentence as well. Thank you.

DR. SANDLER: I have a comment on that. There's a typo here which could cause some confusion. "The same" -- not "H A S" --

MS. ROGERS: It should be "H S A."

MS. TURNER-BAILEY: Okay. Any other questions or comments? Commissioner Hagenow?

MS. HAGENOW: I don't know if it's a motion yet, but the two things that are important from my perspective are that we do, indeed, move this first level. I look at, just in a very simple way, if somebody comes to the hospital, first, that they have access if they can get there. The second thing is they have access if we have what is needed for them. So the two tiers, it seems to me, are tied together. So is the motion to move it to the next stage or to take the action on this initial phase and at the same time, concurrently, to work into the work plan expeditiously the next SAC around the second tier of access? I don't know if I've got the right wording, but --

MS. TURNER-BAILEY: I think that's an acceptable motion. Is there support?

MR. DELANEY: Support.

MS. TURNER-BAILEY: Support by Commissioner Delaney. Is there any discussion? And I assume, Commissioner Hagenow, you're including the amendment proposed by the Department?

MS. HAGENOW: Yes; and the amendment as proposed by the Department.

MS. TURNER-BAILEY: With the corrected spelling?

MS. HAGENOW: And the corrected spelling.

MS. TURNER-BAILEY: Commissioner Deremo?

MS. DEREMO: Does that motion include the examination of the two-mile replacement zone that was -- that was -- I did not see those in the recommendations for future SAC study.

MS. HAGENOW: So the motion I was making was the charge as they had identified it. But if we need to add to that charge --

MS. TURNER-BAILEY: I guess my comment -- I'll call on myself -- to that would be if and when we set up a new SAC, we can give them a charge to include whichever areas we think they should look at. They don't necessarily have to, 100 percent, coincide with the recommendations that came out of the previous SAC. If we want to add, we can do that. I don't think it affects your motion for --

MS. DEREMO: So we're not constrained by Commissioner Hagenow's motion based on what we may decide needs to go into the report, then?

MS. TURNER-BAILEY: Well, I heard -- Commissioner Hagenow's motion -- and you can correct me if I'm wrong -- was really to -- it dealt most specifically with the report of the current SAC, but also, at the same time, to expeditiously include in the work plan another SAC which would deal with other issues that weren't dealt with in the first one.

MS. DEREMO: Thank you.

MS. TURNER-BAILEY: And I don't know if you were specifically saying they had to be those --

MS. HAGENOW: Well, I was taking these recommendations. But I would guess that if we're looking at time line and work plan, we're going to have to make that -- write that charge up very clear; we'd probably start with that page 5, "Recommendations for next SAC study," that's on the back of the report itself and bring that

here and say, “Do we all agree on this charge?” and look at the time line of the summer, since that’s when we’re going to have the University help.

MS. DEREMO: But what’s not included in there is the two-mile replacement --

MS. HAGENOW: So maybe we should write that on there right now, number 5, the two-mile -- moving within two miles. I’d be fine with that.

DR. SANDLER: How about --

MS. TURNER-BAILEY: Commissioner Sandler?

DR. SANDLER: Does Mr. Asmussen wish to write out those comments he made as a charge we could think about whether we wish to include? You specifically asked us to include something. But we probably need something in writing so the commissioners can look at it to make certain that’s what we want to do.

MR. ASMUSSEN: I’d be happy to.

DR. SANDLER: Then we could decide whether that additional should be in the charge or not.

MS. TURNER-BAILEY: Mr. Styka?

MR. STYKA: I’m sorry. I was distracted. I didn’t quite hear what the doctor just said. But it seems to me that the clearest way to deal with this is to have -- as I understand Ms. Hagenow’s motion, it’s to move this forward to the next stage, public hearing, et cetera. And it’s also to have this body develop a new charge for additional study of the access issue. I think if you look at it that way, then later on in the meeting, you’ll have another motion to deal with what should be in that charge. So that way you don’t have to worry about Commissioner Deremo’s concerns, et cetera, right now; you’ll get to it in a little while --

MS. TURNER-BAILEY: I agree.

MR. STYKA: -- and clean up the discussion that way.

MS. TURNER-BAILEY: That was what I was trying to say. Really, the important piece that we need to deal with at this moment is a recommendation from the -- from the SAC as it was presented to the Commission. We will, eventually -- and it sounds like we’re in agreement that we need to appoint a new SAC, in which case we would have to also -- need to create a new charge. We can make our decisions on what should be in that charge at that time. And I don’t know that we have to develop the charge today, because, frankly, it sounds like it fits better in the work plan a little bit later on in the year, in any case, maybe starting with the March meeting. Any other questions or discussion? (Off the record interruption)

MS. TURNER-BAILEY: All those in favor, please signify by raising your right hand. ALL: (Affirmative response)

MS. TURNER-BAILEY: It’s unanimous. Thank you very much. And, again, Mr. Steiger, other members of the committee, we very much thank you for your work. We appreciate the work that you did. And I think I agree with Commissioner Hagenow, it was something that we could understand and explain and walk through in a very really understandable way. Thank you very much. (Off the record interruption)

MS. TURNER-BAILEY: We’re going to break for lunch. I am going to keep it short, though, because, again, we still have a very full afternoon ahead of us. I want to try and accommodate Mr. Styka’s schedule; he needs to get out of here fairly quickly. So we’re going to reconvene at 12:45. It’s 12:15 now. We’re going to reconvene at 12:45. Thank you.

(Off the record)

(Lunch break from 12:15 p.m. to 12:55 p.m.)

MS. TURNER-BAILEY: It's 12:55, which is just a few minutes past what -- our planned start time. We're going to move on with the agenda. Next on the agenda is the CON Commission bylaws. As those of you attend regularly know, this was an assignment that the Commission had, which was to take a look at the Commission bylaws and make any changes that we think might be necessary. Mr. Styka has worked on those generously along with Commissioner Goldman, who had volunteered to be the Commission liaison for this particular project.

MR. STYKA: Also Bill Hart at the Department took part in --

MS. TURNER-BAILEY: Thank you -- and Mr. Hart. And we appreciate -- when he comes back, we'll make sure he learns of our appreciation. Mr. Styka?

MR. STYKA: The Commissioners have a draft, and this is not meant to be -- I'm not speaking as your lawyer saying, "This is what you've got to adopt." I'm speaking as your servant here, trying to come up with a set of bylaws that matches the changes that have occurred in the law and as a result of the action of the Ethics Board last year -- or this year, rather, earlier this year. I'm going to kind of reference quickly the old bylaws as I talk about the new ones, so you know where the changes are. The preamble I just left the same. If you want to change that, you need to tell me and we'll come up with language. It's pretty basic. It talks about the statutory authorities. All we did was add the reference to the latest provision, the Act 619, 2002, and then we did some correcting because we no longer have 12 articles, we have 10. So we had to change a reference or two in there. The definitions, this is pretty standard in all rule making. It's standard in bylaws to say that the definition of the bylaws are the same that you'll find in the statute. The "General Purposes," now, here again, I didn't make any changes. If you think you need or have different purposes than what have been laid out traditionally in the bylaws, speak up, and I will try to draft something to add or delete from there. But I think that the purposes which have been there from '89 are pretty general, pretty much explain what you do. Any comments on that? (No verbal response)

MR. STYKA: Okay. Article 4 used to be "Ongoing Functions." And because all it was a re-statement of what's in the law anyway, it just seemed to me to be unnecessary language to have in the bylaws. There was nothing in there that isn't already provided for by the legislature in one way or another, and it was just duplicative to have it in the bylaws. So we did not -- I recommend not continuing the old Article IV, "Ongoing Functions." And I don't know if you have copies of the old version -- you probably don't -- in your packet. That said things like -- right out of Section 22215 that your job is to revise or, you know, add to or delete from the new standards and to the list of critical -- covered services and just all the different things that the statute says you're supposed to do. So it just didn't seem appropriate to have that restated in the bylaws. Similarly, Article V -- the old Article V was oversight by the legislature and the governor. And, again, this is spelled out in the code and it doesn't need to be duplicated in the bylaws. It's just unnecessary. How the governor and legislature oversee is all directly stated in the code in terms of sending reports to the committee, et cetera. So we -- both Bill and I decided that was not a good thing to have in there anymore; sort of a waste of paper. So your Article IV now is what used to be Article VI, only it used to be "Ad Hoc Advisory Committees," now it's "Standard Advisory Committees." And this is one we need to take a closer look at, because it had to be written new because of the change in the law. So we said, "If the Commission determines it necessary" -- just like the law says -- "it may appoint a Standard Advisory Committee to assist in development of standards," et cetera, and then references the statutory section. It says, "The duties of the committee shall be developed and approved by the chairperson" -- now, you need to think about is that how you want it done -- "the chairperson of the Commission after seeking advice and comment from the members." This way, we're not trapped into what we used to run into, where you had to have a big session where you talked through what exact language was going to be in the Commission, and then formally vote to approve it. Now what you can do is you can give direction through the meeting to the chairperson who can then worry about the commas and the colons and give the charge to the committee. If that's satisfactory with you, that's what we'll have in it. If you think that's not a good idea, speak up. This is a good chance to voice --

MS. HAGENOW: Are you taking comment now?

MR. STYKA: Oh, yeah; on this one. You know, let's go as we go.

MS. HAGENOW: The thing that isn't clear in these ABC is that there is a formulated charter for the scope. I don't know that -- it says, "after seeking advice and comments." Would it be well to clarify that -- a developed charter with scope --

MR. STYKA: Do you mean the charge?

MS. HAGENOW: The charge.

MR. STYKA: Okay. That's what's implied by saying "the duties of the Standard Advisory Committee shall be developed and approved by the chairperson of the Commission after seeking advice and comment of the members and the Department." If you want me to add some language about a charge, I can.

MS. HAGENOW: Well, it just seems like it would be best if the charge were -- we understood it and that if people thought there was more that needed to be there, that we could talk about that, rather than that it just becomes rather arbitrary and somebody decides, "This is the charge."

MR. STYKA: Is there a consensus on this? Are you guys --

MS. HAGENOW: I'm just throwing it out for --

MS. TURNER-BAILEY: Well, I think I like it the way it's written because, again, it doesn't -- as you mentioned, it doesn't tie us to meetings. So we can discuss during a meeting what we think the charge of a committee could be, but the chairperson could finalize that charge at some point prior to the next meeting.

MR. STYKA: Maybe a practical example would be today, what came up earlier. We have -- I can't remember if it was 5 or -- whatever the number of points were that the SAC recommended be in another SAC charge. And then Commissioner Deremo mentioned another one. Well, the way I envisioned -- as I understand this would work, I mean, you guys would do a motion and say, "The charge should include the following" -- six, seven, eight points. And then instead of having to work out all the comments -- we used to sometimes spend a lot of time -- Former Chairman Maitland can remind everybody -- a lot of time working on the exact language of these things, where probably the chairperson can do that once they've got from all of you, through your discussion and a motion, what needs to go in there. And that's really what's intended. If you'd like a little more language on that, I can maybe try to --

MS. HAGENOW: Well, I'm not at all for bureaucracy, that's for sure. And if the duties as clarified is good enough, then -- I seek other people's input, but I think that --

MR. STYKA: Well, again, this is your --

MS. HAGENOW: It sounds a little bit --

MS. TURNER-BAILEY: Is there a reason you chose the word "duties" versus "charge"?

MR. STYKA: Just because "charge," you're starting to think about what words, exactly, are written down instead of just getting the parameters of what is needed -- you know, what the thrust of it should be.

MS. ROGERS: Could you put "charge" in parentheses?

MR. STYKA: I could put the word "charge" back in, if you want.

MS. TURNER-BAILEY: Well, that's a good idea that Brenda suggested; maybe put the word "charge" in parentheses.

MR. STYKA: Well, I don't know -- parentheses are never -- not usually a good idea. Maybe we can -- let me get out to you maybe an additional sentence or something.

DR. AJLUNI: How about "the duties as described by the charge"?

MR. STYKA: There you go. Or "the duties that shall be contained in the charge," --

MS. TURNER-BAILEY: Yeah.

MR. STYKA: -- something like that. Let me throw something back at you.

MS. DEREMO: I think there was another --

MR. STYKA: Go ahead.

DR. AJLUNI: No; I'll pass.

MR. STYKA: Doctor, was there something --

DR. AJLUNI: No.

MR. STYKA: Okay. "The appointment of the advisory committee shall be effective as of the date of the first meeting of the committee." This is to resolve one of the issues that came up during the last SAC, the hospital bed SAC. You know, you have the six-month limitation and from when does the clock start running? You could actually have a meeting, decide on duties charged, go to appoint people, and although you took action, let's say, at your March meeting, it's July before it all gets put together. Now, all of a sudden two or three of the months that you would have had to function are gone. So what I tried to do here was to make it that while you're appointing these people, or the chairperson is appointing these people, the actual effective date of their appointment is that first meeting, which gives them the full six months to operate and to have their meetings and to get together their recommendations. I'll throw that out to you. Yes?

MR. GOLDMAN: I don't have the statutory language here, Ron. Is there anything in the statute that suggests that the SAC starts at an earlier date?

MR. STYKA: It says from the date they're appointed. So what I did was I said the appointment shall be from the date of the first meeting.

MR. GOLDMAN: So the statute says the date they're appointed. We would have to say, "We hereby appoint the following members, said appointment to be effective" as of some date in the future?

MR. STYKA: Right.

MR. GOLDMAN: Because otherwise we've got -- there's a conflict between the statute and --

MR. STYKA: Well, no. That's why I'm trying to resolve it by having in the bylaw the fact that the appointment will be as of the first meeting.

MS. TURNER-BAILEY: I understand.

MR. STYKA: That way you don't have to every time remember and have in a motion what that date will be or that it will be the first meeting, because it will just be a fact through the bylaws that the appointments are effective as of the date of the first meeting. Does that -- is that all right, Commissioner Goldman?

MR. GOLDMAN: Yeah; I -- it just -- it's a little tricky because the language as I was recalling was fairly specific in the statute. And I just didn't want to get into a statutory interpretation problem.

MR. STYKA: I tried to be very careful in there to accommodate that. What 15 L -- I guess it's -- 1L says, "If the Commission determines it necessary, appoint Standard Advisory Committees to assist in development of proposed standards. A Standard Advisory Committee shall complete its duties under this subdivision and submit its recommendations to the Commission within six months, unless a shorter period of time is specified." So looking at that language, it seemed to me that the appointment date was the critical one. So I

tried to build in an automatic appointment as of the date of the first meeting. You name the people, but their appointment takes effect at the date of the first meeting, through this bylaw.

MR. GOLDMAN: Okay. So -- and that should be consistent with what the state -- I mean, people on this Commission don't officially get appointed until some point after they have been chosen, and that's what you're building in here?

MR. STYKA: Yeah; in a way.

MR. GOLDMAN: Okay.

MR. STYKA: "C" is that the chairperson of the advisory committee shall be appointed by the chairperson of the Commission. That's really the same as we had with the ad hoc committees. "D" is a member of the advisory committee shall be subject to the provisions against conflict of interest that are set forth later, again, just as we did before with the ad hoc committees, and the last one, that their meetings are subject to the Open Meetings Act, which I think has to be anyway, and that is consistent with what we did before. Yes?

MR. GOLDMAN: In looking at what the last SAC did, they had meetings of the Standard Advisory Committee, but they also empowered some subgroups --

MS. DEREMO: Workgroups.

MR. GOLDMAN: -- workgroups, some of whom had different composition than the Standard Advisory Committee. Are we going to run into a problem with the Open Meetings Act if SAC's, on their own, empower other groups like that?

MR. STYKA: Well, you're throwing a new question at me. And it has -- I can see where I need to really do a little research to be able to answer that.

MR. GOLDMAN: I was thinking about it this morning when they were talking about the workgroups. The workgroups were obviously very helpful and, especially given this six-month time frame, probably very necessary to get the work done. But if the workgroups are created by the SAC, I just wondered about the Open Meetings. I don't expect an answer right now, but I think it's something to think about.

MR. STYKA: Well, this is -- you know, my train of consciousness in thinking about this, these are advisory to the SAC. They don't make any final determinations. Public bodies can always come up with advisory committees or subcommittees, even though there's nothing in the statute or rules that creates them, as long as they're advisory to them. Really, the only legal issue would be whether or not those advisory committees are subject to the Open Meetings Act, and I think they are. But I don't think there would be a problem.

MS. TURNER-BAILEY: Commissioner Sandler?

DR. SANDLER: Along the same lines, Ron, if we're going to ask that workgroups come together -- there's a workgroup on MRI -- rural MRI issues and things like that and it's a workgroup of all the stakeholders coming together attempting to reach a consensus with the departmental representatives -- where does that figure in here?

MR. STYKA: It's not in here.

MR. GOLDMAN: It should be.

DR. SANDLER: Now, is that a problem with the Open Meetings Act? Is that a problem with issues with -- where the chair of the Commission asks that a workgroup be formed and asks them to be certain that the stakeholders are there, we got points and information with the liaison? What does that do to it?

MR. STYKA: As far as the Open Meetings Act question goes, I think we're going to need you to ask that question in a more formal context so we can give you an answer, because I don't know off the top of my

head. As far as doing that process, that arises out of Section 22215 as well, because you can act directly and acting directly is a little difficult without having some sort of basis to act from. So we don't have a section in here on that. We can come up with one if you'd like. I guess I need a consensus if you really want me to do that.

MS. TURNER-BAILEY: I think we only need to do that if it turns out there's something special we need to do relative to the Open Meetings Act or something along those lines. Because the ability to do the workgroups is defined in --

MR. STYKA: Right.

MS. TURNER-BAILEY: -- the law; right? So I don't think we need to put anything -- this is just my non-legal thought about that.

MR. STYKA: Right.

MS. TURNER-BAILEY: I have a question about Article IV. It's been the practice of the Commission in the past to allow the chairperson, or the chairperson in concert with the vice-chair, to appoint the members of the SAC. And it doesn't really state in here -- we have sort of these various bullet points; for example, the chairperson can appoint the chairperson of the Standard Advisory Committee. But it doesn't say that the Commission can kind of delegate their duty to appoint the SAC to the chairperson.

MR. STYKA: Quite frankly, I missed that one. We can add that in, empowering the chairperson of the Commission to appoint the membership. Now, traditionally, that's been done because this group decided to give that power on a case-by-case basis to the chairperson.

MS. TURNER-BAILEY: Right. And I don't think --

MR. STYKA: Maybe they would still like to do that. We need to know.

MS. TURNER-BAILEY: I think we should. And I would be interested in comments from the other commissioners. I think we should do it on a case-by-case basis. But we should make sure that the ability to do it is there.

MR. STYKA: Well, it is. It doesn't need to be in the bylaws for that to be case. If you put it in the bylaws, we might -- it may almost bypass, depending on how it's worded, the Commission saying to the chairperson, "Go do this." So it would be automatic. Commissioner Deremo?

MS. DEREMO: Along that same line -- this is Commissioner Deremo -- and we have a wonderful chair and vice-chair and excellent Commission members, but in Number A, where it says that the chairperson would basically develop the charge after the Commission had outlined duties that might be contained in the charge, is there any provision or has this happened in the past where the Commission has outlined general duties and then there has been some pressure from the left field that would add something that was not within the confines of the duties that were discussed within the Commission that the chair then charged the SAC with?

MR. STYKA: It has not happened in the past. I mean, I can see how you can envision that being a potentiality. But it hasn't happened.

MS. DEREMO: Because I think there's a balance between assuring that there's not bureaucracy and there's fast movement in that the chair and the vice-chair have the flexibility to get the work of the Commission done. On the other hand, where is the boundaries of that so that if there's something that's totally outside the charge of those duties and there's been some kind of pressure from special interest -- not that it would happen -- but I'm just kind of -- just speculating and putting that out there for some discussion.

MR. STYKA: That section is going to have to be revised, just from the prior conversation. But part of that will be making it clear that the parameters of the charge are decided by this group; that the detail, in a sense, the actual --

DR. SANDLER: The drafting.

MR. STYKA: -- language, drafting, will be given to the chairperson.

MS. DEREMO: I don't see those boundaries here in this language.

MR. STYKA: No; we're going to redo it to do that.

MS. DEREMO: Okay. Great. Thank you.

MR. STYKA: Article V -- the new Article V is "Membership of the Commission," which would line up, I guess, with what used to be VII. And of course, that's changed a lot because the statute changed. The first part is, in fact, just a repeat of what's in the statute as far as where the individuals have to be from, that there are eleven members. Then we get to term of office. That, again, is something that's decided by statute. But I tried to make it clear here, number 1, that the Commissioners -- because this is what the stated law is, the commissioners take office upon appointment of the Governor, and unless rejected by the Senate, the commissioners serve until their office expires or their resignation is accepted. So that's just a statement, not necessarily of what's in your statute, but what the law does provide for bodies like this, that are approved with the advice and consent of the Senate. Number 2, the members, with the exception of the initial members, serve for three years or until a successor's appointed. The three-year part is by statute. The "or is appointed" is just to clarify again -- restate what is already clear in the law generally. And that is if your successor doesn't get appointed, you continue to sit until the Governor gets around to doing that. That's just the way it is in Michigan. Yes?

MR. MAITLAND: Shouldn't that be in paragraph 1, too -- or 1, also, I mean? (Off the record interruption)

MR. MAITLAND: Because, you know, it's the same thing, until their office expires or -- office expires, a successor is appointed, or they resign. Otherwise –

MR. STYKA: Good point.

MR. MAITLAND: -- you're basically saying they're done.

MR. STYKA: You know, it's in one -- I don't know if it needs to be in both places. But we can do that. (Off the record interruption)

MR. STYKA: Now, C is "Quorum, Voting Procedures and Proxy Votes." And some of this is a rehash of the old one and some of this is new. The law clearly makes it true that a majority of the appointed and serving are quorum, so you can't have less than 6 here and have a quorum and that final affirmative actions are a majority of those appointed and serving. So if there are, in fact, 11 appointed, 6 is what's needed to pass -- to take an action. Again, that's what's in this law. So it's just a restatement of it. 2, "Actions not resulting in final action, including recommending action by the full Commission or completing other planning tasks, may be made by a majority of those in attendance," the reason why that's possible is because those aren't the actions that are contemplated that require the 6 votes in the statute, it uses "final action" in the statute. So you can get away with having, if there's only 10 of you here, or 8 of you here, a 5-vote or something like that for these recommended or preliminary actions. It's the final actions that require the 6.

MS. TURNER-BAILEY: Is there a question? Commissioner Ajluni?

DR. AJLUNI: Ron, in the past we've had some commissioners that have participated by phone.

MR. STYKA: We're getting to that. That's in here.

DR. AJLUNI: Oh, it's coming? Okay. Sorry.

MR. STYKA: Thank you. That is coming. And then 3 is, again, a statement of what we understand the law to be. A CON Commission member shall not vote by proxy. A proxy by a Commission member shall not be seated, nor shall they vote or offer motions or seconds. I mean, you're the one appointed by the Governor. You've got to be here or you're not here. Okay. Now, the exception to that, teleconferencing, will come in the next article. Article VI, meetings of the Commission, some of this is sort of rehash of the old and some of this is new. A, compliance with the Open Meetings Act, we know you have to do that. B, Robert's Rules of Order -- now, I wanted to make it clear in here that Robert's Rules of Order are nice, but sometimes the law overrides them. So the statement is, "The commissioners' procedural activities shall be governed by Robert's Rules of Order, Revised, insofar as they are consistent with state law and these bylaws." For example, the chairperson can make the motion, and Robert's tends to say you can't. And that is not true of an appointed or elected body; that's just one quick example. So to make sure that we understood that, I added that little phrase. Notice of meetings, the Department shall make available the times and places of the meetings of the Commission; that's standard. D, Regular and Special Meetings, this is pretty much standard, what we had before. You've got regular meetings quarterly, announced in September for the next year. You've got not less than -- oh, excuse me. Now, number 2, I should have made a modification. I'll ask all of you -- actually, not necessarily. I'll ask all of you. The language here says special meetings can be called by the chairperson or by three commission members, or by the Department. Actually, it's probably the right number. This is the idea that you need a special meeting and maybe the chairperson doesn't think so, maybe the Department doesn't think so. But how many commissioners should it take to call a special meeting?

DR. SANDLER: If you say three for the sake argument, if three commissioners actually agree on that there has to be a meeting; is that --

MR. STYKA: That's the idea.

DR. SANDLER: There has to be a meeting?

MR. STYKA: Yes. (Off the record interruption)

MS. TURNER-BAILEY: Well, we've successfully called special meetings. But generally everybody has to agree, because we have to look at calendars, et cetera. So I don't know.

DR. SANDLER: It's a practicality --

MS. TURNER-BAILEY: Yes; it's a practical matter.

MR. STYKA: As an example, I sit on a school board. I'm elected -- a school board member. Those are seven-member bodies, and any two of us can call a special meeting. Okay? The chairperson can, or any two of us. And so this is that same logic. Now, this doesn't mean everybody is going to be able to show up, and you've obviously got to be a little bit a politic about it as to when people might be available, et cetera. But that's the idea.

MS. TURNER-BAILEY: Three seems like a small number to me. But I don't know what -- I have no idea what the right number would be.

MS. DEREMO: That's about a third; a little under a third.

MR. GOLDMAN: Actually -- this is Commissioner Goldman. The rationale behind that kind of rule is to prevent a minority from getting stampeded. It is used very, very rarely. But at least it allows three members of the Commission to say, "Something bad is going on, we don't think it's right. We want to at least have an open meeting and bring it to the attention of the other members of the committee." Frankly, the other members of the committee can simply not show up, and then you don't have a quorum. So Ron's right that this is something you have to use in a very politic fashion. But it's standard in bylaws to allow a minority of a committee to try to force an open meeting.

MR. STYKA: Actually the statute says three is the minimum. So the question is whether you want it bigger than three.

DR. SANDLER: I suggest we -- it's something that's likely to be unused -- but we just leave it.

MR. STYKA: Okay. Is that all right?

DR. YOUNG: That's fine.

MS. HAGENOW: Uh-huh (affirmative).

MR. GOLDMAN: Uh-huh (affirmative).

MR. STYKA: Okay. A regular or special meeting of the Commission may be recessed or reconvened consistent with the Open Meetings Act. Again, that's just a statement of what has developed as the law with regard to Open Meetings Act. "Meeting Attendance," this arises out of this statute as well. "Members are expected to attend all regular and special meetings except on those occasions where good causes exist. When a member of the Commission is aware that they're unable to attend" -- this is something that was in your old bylaws, I believe -- "every effort should be made to advise the Department, the chairperson" -- I think it says here the Department, or the chairperson or the vice-chairperson, depending on the situation, that you're not going to be there. So if it looks like there's only going to be five people, you can't have a meeting, they can know that ahead of time and deal with it. Any problem with this? Doctor?

DR. AJLUNI: Just a minor thing. It says "Notify chairperson and vice-chairperson." I think it should say "or."

MR. STYKA: Yeah; it should. You're right. Very good. Any other problems with this one? (No verbal response)

MR. STYKA: "The chairperson of the Commission shall determine whether a good cause exists for the absence of a member from a regular or special meeting. When the attendance of the chairperson is under question, the responsibility for determining good cause falls on the vice-chairperson." The reason this is important is because the statute talks about failure to attend -- the next section -- failure to attend three consecutive meetings being the grounds for you being removed from the Commission. But if there's good cause, it doesn't kick in. So you can be seriously ill and go past three meetings, and the chairperson would say you had good cause not to be here for one, two, or all three of those. But it's important because the statute does talk about you being possibly removed by the Governor if you've missed three in a row, with the exception of good cause. Is this okay with everybody? ALL: Uh-huh (affirmative).

MR. STYKA: All right. And we sort of talked about -- teleconferencing is what Dr. Ajluni was wondering about. I've written this up: "Teleconferencing shall be allowed in accordance with the Opens Meeting Act. Upon approval of the chairperson, CON Commissioners may appear at a meeting via electronic device, including speakerphone or interactive television, provided that a quorum is present at the meeting site" -- so you'd have to have at least six members here -- "and all individuals attending the meeting," which means the folks out there, "can hear and can be heard by the commissioners or commissioner attending via electronic device." We had this experience without having a bylaw on it, when your vice-chairperson was ill. And this codifies it into your bylaws and makes it clear what -- because the last time we were kind of scrambling, "How do we do this?" And this way, it's spelled out. Any questions or problems with -- Doctor?

DR. AJLUNI: One of the last times that I recall the electronic -- the speakerphone, voting took place and it was somewhat difficult to hear the votes of the people who were on the phone.

MS. HAGENOW: That's true.

DR. AJLUNI: Should we put a sentence in there with regard to voting? Or do you think that's unnecessary?

MR. STYKA: Well, it's meant that -- when it says, "individual attending can hear," it's meant that they can hear, including the voting. So what it means is that we have to have better equipment next time so that the sound is clear throughout the room.

DR. AJLUNI: I mean more to the point that the votes would be tabulated and counted, obviously. But that's not necessary to put that in if --

MR. STYKA: I think the chairperson just needs to make sure that, you know, you're voting in a manner that -- whether it's voice, phone, or having -- asking the person how they vote or whatever. Yes?

MR. MAITLAND: This is Maitland. Personally, I'm opposed to this kind of meeting attendance. Can you give examples of any commissions in the State of Michigan that use this? The NRC doesn't, the AG Commission certainly doesn't.

MR. STYKA: It's frowned upon in state government, although it has been used occasionally. And I -- you know, I don't represent all the commissions in state government, so I can't answer the question.

MR. MAITLAND: Well, you can't give me an example of one other one that does it, I take it?

MR. STYKA: No. But I know that sometimes administrative law judges will hold hearings using these kinds of devices where lawyers or even respondents are not present.

MR. MAITLAND: They're not subject to Open Meetings Act, probably.

MR. STYKA: Oh, yes, those are subject.

MR. MAITLAND: Okay. Well, they are. But I personally am opposed to it. I think it's cumbersome and I don't think it's right. If you have a meeting, you should be able to attend. I understand there were circumstances - - it seems to me there was two people on that line, wasn't there?

MR. STYKA: Yeah; there were.

MR. MAITLAND: And I'm not sure what the circumstances were. I just don't think it's right.

MR. STYKA: Well, right now, the way I've worded this, it says, "Upon approval of the chairperson Commission members may appear at a meeting electronically." Now, if you want to revise that, we could revise it to a majority vote of the commissioners. The problem with that is you always have to have a quorum there. Well, that's workable. You know, we could do that. Yes?

DR. AJLUNI: I think we should leave it in and I think we should look ahead to not only two years from now, but five or ten years from now this is going to become more and more prevalent. We may be meeting by videoconferencing, we may have consultants coming in by videoconferencing. I don't see anything wrong with it as long as the technology is there and everyone is able to be heard, as your statement says.

MR. STYKA: This does have the insurance that at least six are here. And go ahead.

MR. MAITLAND: And videoconferencing is a lot different than trying to listen to somebody on the telephone. I might not be opposed to that. And I know hospitals are using that a lot now. So maybe that's -- if it is videoconferencing, maybe it would be a little better than just on the telephone.

DR. SANDLER: The State Medical Society board meetings does allow for videoconferencing, but does not allow basically audio conferencing. It had it, but audio conferencing just isn't very good, so we've opted for videoconferencing.

MS. TURNER-BAILEY: Well, I think it goes back to your point. We have to make sure that the equipment is adequate to do the job. And, you know, we've had historical issues with microphones and other pieces of equipment. But -- I don't know. I guess my experience is people have not abused that privilege and only

asked to do it if there's just absolutely no way for them to get here and they feel their input would be valuable. And so I guess I would leave it in as is.

MR. STYKA: Well, I'm not lobbying for any particular result. In fact, I kind of frown on these, myself. But anyway -- but these are your bylaws. So I guess I need to know from all of you -- a majority of you, whether you want it to say anything, number one; number two, if you do want it to say something, do you want it to say what I wrote here, or number three, take out the phrase "including speakerphone" and just leave it "interactive television"?

MS. DEREMO: In my experience, Hospice of Michigan has board members from all over the state. And we do have videoconference and teleconference -- meetings by phone and by videoconference. Sometimes the audio conference is better than the teleconference, and it depends on the equipment. But it also is respectful of if we were to have -- when we have commissioners that may be in the Upper Peninsula and there's major snowstorms and --

MR. STYKA: Or in a hospital.

MS. DEREMO: -- or in the hospital. I mean, I think that we do need to take those things into consideration so that we allow commissioners to participate from all over the state. And sometimes restricting that will limit to those who are in the Lower Peninsula.

DR. SANDLER: I --

MS. TURNER-BAILEY: Yes?

DR. SANDLER: I would suggest that we just keep it in -- understanding Commissioner Maitland's concerns, but as Commissioner Ajluni said, the technology is going to improve in the future. And I think the reason that commissioners would do this is simply to continue to be connected to the Commission on that date and not going to participate as much; that's obvious. But at least they would be connected. You know, if you had a meeting out of town, you might be able to catch a few hours in your hotel room, for example, or something like that. (Off the record interruption)

MS. TURNER-BAILEY: Any other comments on this Article VI, Section F?

DR. YOUNG: Leave it as is.

MS. TURNER-BAILEY: Okay. I'm hearing a consensus to leave it in and leave it as is.

MR. STYKA: I was about to ask you to get me the consensus.

MS. TURNER-BAILEY: I'm taking my own private vote here and I'm seeing lots of nods. Okay. We're leaving it in as is.

MR. MAITLAND: I can live with it.

MR. STYKA: Again, these are going to come back to you. And you all have these drafts. So feel free to mark up, write new ones, whatever you need. Because next time I assume you'll discuss them again before voting, and you can amend them at that time.

MS. TURNER-BAILEY: Well, let's talk about that after we go through the whole thing, kind of what the process should be.

MR. STYKA: Okay. The next article, Article VII, it's just adapted for the new circumstances, mostly. Election of chairperson and vice-chairperson, no real change there. You should note that the original bylaws and these say that the chairperson can't serve more than three consecutive terms. If you don't like that, it can be changed. It's not in the law. It's up to you. But back in '89, that's what they decided would be good. The chairperson and vice-chairperson of separate parties, I believe, is in the law. And there's a historical

trend of alternating those; in other words, the vice-chairperson becomes the chairperson, et cetera. But that's not in the law. That's up to you guys. So that's not in here. The procedures for electing the officers, that's standard. You've got nominations by those in attendance, and that's only for those that are actually here that can nominate. We can change that if you want, to be consistent with teleconferencing. "Election of officers shall be determined by an affirmative vote of a majority of those appointed and serving." That means you've got to have at least six votes to get elected. Any comments on any of those? (No verbal response)

MR. STYKA: Okay. Responsibility of the officers, 1 is pretty much what it was before. The chairperson, or in his or her absence, the vice-chairperson shall preside at the meetings. In the event that neither one of them is available, then the rest of you elect somebody to be temporary presiding officer for that meeting. Number 2 is changed; it's new. The duties designated to the chairperson in the Public Health Code and in these bylaws, in the absence of the chairperson shall be performed by the vice-chairperson or the temporary presiding officer. Looking it over, I realize we didn't -- it wasn't spelled out anywhere. And you do have duties in here; like, for example, when you come up with the charge that the chairperson goes back and puts the commas in, et cetera; so if they're not available, this makes it clear that it can be done by the vice-chair, or if we're in a presiding officer mode, that it can be done by the presiding officer. Any issues with that, or problems? (No verbal response)

MR. STYKA: The next one is filling the vacancies. And this is pretty much what you had before. If the office of chairperson becomes vacant, the vice-chairperson moves up and serves the remaining months. If the office of vice-chairperson becomes vacant, the Commission shall elect a new vice-chairperson and they serve out the remaining months. If the office of both become vacant simultaneously, the Commission shall conduct a special election to fill those positions. New officers shall be elected by an affirmative vote of the majority of all those appointed and serving. So it's the same thing again. And it's throughout the remaining term. We have to have it so that people serve out the remaining terms in order to keep the three or four coming on board every third year -- or every year, consistent with the statute. Article VIII, Parliamentary Procedure, is what you had before. The attorney general is your parliamentarian. B I revised a little. Any question arising concerning procedure at a meeting of the Commission shall be resolved by the presiding officer in accordance with the -- and this is the addition -- with the laws of the state, these bylaws, or Robert's Rules of Order. It used to just say "Robert's Rules of Order." We've got to make -- it's just a clarification that those sometimes are overridden. And C is the --

MS. TURNER-BAILEY: You wrote "and" here, though.

MR. STYKA: I'm sorry?

MS. TURNER-BAILEY: It says "and Robert's Rules of Order."

MR. STYKA: It is an "and." You know, you resolve it using all three. And then C, the attorney general is the designated -- or his designee, me, shall serve as legal counsel for the Commission. Again, that's what consistent with what's in the statute, and that's what was in the old bylaw. Article IX, is -- except for part A, I'll redraft it. And that's because of the activity that occurred earlier this year -- late last year and early this year, up through November of this year, with the Ethics Board. And sub-A is just citing the three statutes that apply, which is parroting the statute itself. B, Definition of Conflict of Interest, this is a new -- this is my attempt to be in conformance with the Ethics Board's rulings. So I state under the State Ethics Act, in accordance with the advisory opinion of November 5, 2004: "A conflict of interest for CON Commission members shall exist when the individual member has a financial or personal interest in a matter under consideration by the Commission. The personal interest of a commission member includes the interest of the member's employer, even though the member may not receive monetary or pecuniary remuneration as a result of the adopted CON review standard." That was the statement of the Ethics Board. But then they did allow us some latitude, so we go to 2: "Commission members shall not be in violation of the Ethics Act, if the member abstains from deliberating and voting upon review standards in which the member's personal interest is involved." That just means that if you're in a conflict, you can't be a part. But then 3 is the exception: "Commission members may deliberate and vote on standards of general applicability; that is, those standards that do not exclusively benefit certain health care facilities or providers who employ the CON Commission member." If you recall, this all arose in a context of allegations -- we're not saying they were true -- but allegations that because one or two commissioners were employed by somebody who actually

was either solely or just the two or three of them were the beneficiaries of that particular proposed standard, the Ethics Board felt that was a violation. So their way to allow all of you who have an interest in this industry -- because you come from some place in the health care industry, whether it's even a practitioner or whether it's part of a hospital, or a nursing home or whatever -- the way to satisfy the argument I made, which was this was a special situation, because these commissioners, by law, have to represent these different groups, and there are always going to be appearances of conflicts, the Ethics Board said what's in 3, you may deliberate and vote on standards of general applicability; that is, those standards that do not exclusively benefit certain health care facilities or providers who employ the Commission member, even if the standard of general applicability would benefit the member's employer or those for whom the member's employer does work. So if you're reviewing a hospital bed standard that applies to all hospitals, or a significant part of the hospital industry, even though it may actually end up benefiting your employer as well, you're not in a conflict, is what the Ethics Board said; you're okay. But if it only benefits yours or maybe two of you and it benefits the two of yours, then you are. Commissioner Deremo?

MS. DEREMO: What this does not apply to is many of us, I would assume, are maybe on boards of health care organizations that have issues that come before this commission. As a Board member, you really don't have remuneration and you are not an employee; you are actually an agent of the community. You're representing the community if it's a non-profit organization. How do these conflict of interest standards apply to Board members?

MR. STYKA: The Ethics Act was focused on -- the statute itself, as well as what the Ethics Board ruled, was focused on individuals and -- employed individuals. They didn't rule on that. I don't think there's a provision in the actual Ethics Act that would answer that question at this point. So if somebody out in the public wanted to raise that issue, it would have to rise all over again in front of the Ethics Board. But I think the statute itself doesn't address that. It talks about an individual's personal interest, including the fact that if they're employed by somebody that employer's personal interest becomes their personal interest.

MS. TURNER-BAILEY: Can I just -- I was thinking -- I actually was watching the proceedings of the Ethics Board and just thinking that over the years, my experience here, this really answers a specific question. I mean, it clarifies that. But it doesn't say this is the only time a person might decide to declare a conflict of interest.

MR. STYKA: True.

MS. TURNER-BAILEY: You may think, you know -- you have to sort of think about on your own what your circumstances are. If it happens to be your own board, and you think that might influence your decision, then I would recommend you say that up front and declare that conflict. And then at that point you can make a decision as to whether you can be included in the voting, et cetera. That's what we've done historically. So I don't know that this -- I don't think we have to spell out every --

MR. STYKA: This is the minimum -- I mean, clearly this is the minimum situation where you're going to be in a conflict.

MS. TURNER-BAILEY: Right. And this is specific. It's spelled out where you're asked the question and this is the answer. But it doesn't cover -- it's not meant to cover every single possibility of a conflict; right?

MR. STYKA: That's correct. And the procedures, Part C here, are a little broader than that, although you have to keep in mind that minimum. But an individual could decide for themselves they have a conflict, even though it's -- you know, it's not even within that minimum.

MS. TURNER-BAILEY: Right.

MR. STYKA: So, then, with C, for the procedures, we have "a Commission member shall disclose" --

MR. CHRISTENSEN: Ron?

MR. STYKA: Yes.

MR. CHRISTENSEN: Could I raise a question, please?

MR. STYKA: Yes.

MR. CHRISTENSEN: It occurs to me that the language in 3 is really a little bit in conflict with itself, in the sense that it says, "can vote on standards of general applicability; that is, standards that don't" -- and, "that is," meaning that explains it -- "that is, standards that don't exclusively benefit the individual." And it seems to me there's a middle category there where the standard might benefit three or four members of the Commission, but might not fit what people would generally term the entire class of people who might -- or agencies or facilities that would fall into that. I think the trouble is with the word "exclusively."

MR. STYKA: Well, that's taken right out of the Ethics Board opinion.

MR. CHRISTENSEN: I know it is. But I --

MR. STYKA: And I really didn't want to mess with it, so to speak. Some of these questions, Jan, I think are just going to have to be decided if the issues arise.

MR. CHRISTENSEN: It just seems like it's in conflict, a bit, with itself.

MR. STYKA: I think it's almost impossible -- they tried -- and they didn't quite make it -- to write an all-encompassing rule. And the Ethics Board did its best, but as you just very well pointed out, they didn't quite do it. And I don't know that we can, either. Okay. For procedures: "Members shall disclose that he or she has a potential conflict, or a conflict, at the start of a meeting, at the commencement of the consideration of a substantive matter, or where consideration has already begun at a point where that conflict becomes apparent." Because you may not know at the beginning of the meeting, before the discussion. You may know, then, at the time the item comes up or you may not. But at some point, if you know, or feel that you have a conflict of interest, that's when you have a duty to raise it. And that what this says. And that is the same as the old one. "Prior to a vote on a substantive matter before the Commission, the presiding officer shall inquire of the membership as to the existence of a conflict," that's what you've been doing and I left that in. I thought that was a good idea. That keeps everybody's mind focused on the fact that these conflicts are out there and we need to be thinking whether we have any or not.

MS. TURNER-BAILEY: Well, I've been doing this at the beginning of the meeting, not before every substantive vote.

MR. STYKA: Actually the bylaws have always called for it before every –

MS. TURNER-BAILEY: And I've never -- I don't remember -- Commissioner Maitland, do you recall doing it before all votes?

MR. MAITLAND: I always followed the rules exactly.

MS. TURNER-BAILEY: Okay. But it's on the agenda, so it's -- I ask people to look at the agenda.

MR. STYKA: Would you like me to change this to "at the beginning of the meeting"?

MS. TURNER-BAILEY: I don't know.

DR. SANDLER: Well, I think one can interject if something is going to be voted -- we don't know if something is going to be voted on. If something is going to be voted on, one can interject very briefly their concerns. I think that would solve the problem. Because you don't even know if something's going to voted on or what's going to be voted on.

MS TURNER-BAILEY: Right. But what he's saying, before the vote, when you know there's going to be a vote, that that --

DR. SANDLER: But it doesn't have to be at the beginning of the meeting is the point I'm trying to make.

MR. GOLDMAN: You could, if you wanted to, say, "At the start of every meeting, the presiding officer shall inquire and at any time during the meeting, the presiding officer may inquire."

MS. HAGENOW: Yeah; that's good.

MS. TURNER-BAILEY: I like that.

MR. STYKA: Very good. We will make that modification. 3 is a protection to make sure we have a Commission that can function. This arises out of legal -- court decisions, et cetera, "A conflict of interest shall not affect the existence of a quorum for purposes of a vote." So if only six people are here and somebody has a conflict on an item -- well, that's actually a bad example. We've got to have six votes. If seven people are here and two people -- well, two people have a conflict, you've still got a quorum, so you can still go ahead with the meeting. You may not be able to vote on that item, but you still have -- you may not be able to pass that item, but you still have a meeting. So that's a protection for that. "The minutes of the meeting shall reflect when a conflict of interest existed and that an abstention from voting had occurred." That's just to make the record, and that's also from the old one. "Where a Commission member has not discerned that he or she may have a conflict of interest and must voluntarily abstain from discussion and vote, any other Commission member may raise a concern as to whether another member has a conflict of interest on a substantive matter. If a second member joins in the concern, there shall be discussion and a vote on whether the member has a conflict prior to continuing discussion or taking any action on the substantive matter under consideration. The question of conflict shall be settled by an affirmative vote of a majority of those Commission members appointed and serving, excluding the member or members in question." This is new. It's a much more detailed -- there was a little tiny sentence in the old bylaws; it really was unclear. I tried to clarify. If you don't like this, I'll take it out. If you want it changed, we'll change it. It's my attempt to come up with some kind of procedure where we have a Commission member who, themselves, don't see a conflict but maybe another member thinks there is one. They raise it. This says, that's not enough. You've got to have two people that think there could be a problem here, which is a safeguard against that one who, you know, looked at themselves and said, "No, I'm not really in conflict." So now you have two people raising it. So you've got sort of a motion and a second, in other words. At that point, you're not going forward with the item because you have to decide this issue. You decide whether or not -- and that's going to require discussion. You -- probably discussion of the individual who may have a conflict explaining the reality of the situation, and people feeling satisfied it's not an issue, or maybe convincing that person they do have a conflict. However it comes out, a majority then determines whether that conflict exists. You don't have to have this in there, but it's an attempt to have a procedure for that remote circumstance where this might come up. Yes?

MS. HAGENOW: I think we should have that in here because of the fact that we have such constituent representation now that this makes for some process. So I value it.

MR. STYKA: Is the process okay?

MS. HAGENOW: I think it is. It's not too onerous, but it has some checks and balances.

MR. STYKA: I thought if just one person raises it and then you have to go to a big discussion, it might be too -- you know, you've got two people who don't like each other -- and, of course, all 11 of you love each other, but if you've got two people that don't like each other, you can end up with this all the time. So that's why I thought you should have at least a seconder before you get into it. Amendment of bylaws is basically the same as it used to be. "Amendments shall be proposed by the Commission or presented in writing to the Commission by the Department or parliamentarian" -- that's new -- "at least 30 days in advance of the meeting where final action is scheduled to be taken. Any amendments to these bylaws shall be deemed to be approved upon an affirmative vote of the majority of the Commission members appointed and serving." So you need six votes. "Amendments to the bylaws shall be effective upon approval or at such a later date as is specified in the amendments." So you could have an immediate effect for an amendment at the time you vote on it. Or if there's such a nature you want to delay that, you can put an effective date right in it; that

the minutes become effective next month, two months from now, whatever. Any problems with that? (No verbal response)

MR. STYKA: All right. So the next question is how do we proceed from here? My thinking was -- but this is your decision -- that you would all, as I said earlier, go back and take a finer look at this, and if you have any notes or anything, get them to the chairperson and she can get them to me. Or get them to Brenda and she can get them to me; whichever you prefer, Renee.

MS. TURNER-BAILEY: Brenda.

MR. STYKA: Okay. Give them to Brenda. Brenda will get them to me. I'll, to the extent I can, incorporate. If they're controversial, what I'll do is I'll write, like, a different -- so you'll have a choice of one or two for a given provision. Suppose Mr. Goldman comes up with a whole new idea for one of these, we'll have the one version, then we'll have the other version. So then when you come in, in your March meeting, you'll have in front of you, hopefully for adoption -- not "hopefully," you will have them for adoption, and you can iron out whatever these suggestions are and either go with the suggestions or leave them as is. I got a few things from today's meeting I'll automatically include.

MR. GOLDMAN: You'd have to give them to us 30 days in advance of the March meeting?

MR. STYKA: Yes. You're going to have to have them February -- whatever.

MS. TURNER-BAILEY: Eight.

MR. STYKA: Okay.

DR. SANDLER: The meeting is March 9th.

MS. TURNER-BAILEY: Okay. So that means we would like to have them to Brenda probably a couple of weeks before that, --

MS. ROGERS: Yeah; so Ron can give them --

MR. STYKA: -- to give you time to put them in. So are you looking at a calendar? Can you give us a date two weeks before February 8th?

DR. SANDLER: 25 of January.

MS. TURNER-BAILEY: Okay. So by the 25th of January, we need to have any suggestions or changes, additions, et cetera. (Off the record interruption)

MS. DEREMO: Would it be possible to get the next draft with a track changes document?

MR. STYKA: Sure.

MS. TURNER-BAILEY: Yeah. That will be --

MS. DEREMO: That would be really helpful, to know what was the old language, what was stricken and what was added.

MS. TURNER-BAILEY: We don't really have a public comment piece, but I've got a card -- I received a card, "Just a short question." Larry Horwitz?

MR. HORWITZ: A real fast suggestion for your consideration. The key thing you've got in here is this whole ethics thing and the conflict of interest, which went on for a whole year. I think the Ethics Board ended up giving you confusion, not clarity, for the very point that Jan Christensen made. One -- if a standard affects one hospital, I got that. That's exclusive. If it affects most, it ain't. Where the this line is in the middle is

really very important, because most things will not affect just one. I would urge your consideration of asking the Ethics Board to clarify the fact that they've given you counsel that doesn't take you anywhere. If it affects two, three entities, is that a conflict or is it not?

MR. STYKA: Actually, their opinion was written in the context of something that affected three.

MR. HORWITZ: Well, but I --

MR. STYKA: So we could almost use that as the guide.

MR. HORWITZ: Right. But then does this thing say that there was a conflict for those two commissioners? Yes or no? I don't know what it said.

MR. STYKA: They didn't rule on that.

MR. HORWITZ: Well, the question you asked -- the Commission asked was about two commissioners' potential conflict, and they struggled with it for nine months and came back with an answer that's rather Delphic in --

MR. STYKA: Okay. I misunderstood your previous statement. Yes; they did rule it was a conflict.

MR. HORWITZ: So does that, therefore, reasonably mean that it isn't just one, it could be a few?

MR. STYKA: If you look at what they did, I mean, the incidence that was before them involved them three -- two people -- two hospitals. In reality, the standard they were looking at was three.

MR. HORWITZ: But the standards affected a few hospitals, --

MR. STYKA: Three.

MR. HORWITZ: -- but more than one; right?

MR. STYKA: Right.

DR. SANDLER: Okay. Obviously --

MR. STYKA: What I would say in response, though, is that these commissioners need to get their new bylaws and get them going. If you ask for another Ethics opinion, it's going to be 2006 before we --

MR. HORWITZ: Well, I just a have it -- I take it your judgment is that this conflict meant that it could be a small number, --

MR. STYKA: Yes.

MR. HORWITZ: -- and that's a conflict?

MR. STYKA: Yes.

MR. HORWITZ: Well, if that's the case, I would urge you to say that more clearly in the document.

MR. STYKA: I tried to use exactly the language that the Ethics Board used, because I didn't want to start writing my laws, so to speak.

MR. SANDLER: I think it's fairly clear. If you're one of only a few hospitals, you have --

MR. HORWITZ: I read the Ethics Board decision.

MR. SANDLER: -- you have conflict.

MR. HORWITZ: I didn't understand where it said the first time --

MR. GOLDMAN: Let me give you an example and see if it helps. If we were, sometime next year, to rule on a standard involving radiologic equipment, Dr. Sandler, as a radiologist, would not be disqualified, because it wouldn't affect just a hospital, it would affect all the hospitals in the state.

MR. STYKA: Correct.

MR. GOLDMAN: If we were to rule on a standard affecting children's hospitals, there's DeVos, there's University of Michigan, there's Detroit Childrens, there's Beaumont, would I be disqualified from voting on that?

MR. STYKA: I would say no, because it's all children's hospitals. What was I think the intent here is that it wasn't a classification of hospitals, but it was carving out a couple of hospitals that was the problem.

MR. GOLDMAN: Even if the standard would in some way be either advantageous or disadvantageous to a children's hospital, it would only be much more specific. If it were something that would directly affect --

MR. STYKA: If it was directly affecting only the largest children's hospital, --

MR. GOLDMAN: Right.

MR. STYKA: -- that would be a conflict.

MR. HORWITZ: But just to make it very precise, there is, in fact, only one children's hospital in the State of Michigan, because DeVos is not a hospital, it's a division of the University of Michigan hospital. So, in fact, there's only one in the state.

MR. GOLDMAN: Well, that's right. Detroit Childrens is --

MR. STYKA: That was a hypothetical, Larry. (Off the record interruption)

MR. HORWITZ: I just used that as an example, though. I think that it really needs -- not today, but some clarification if it only affects two or three to say that, that it therefore is a conflict or is not, whatever the heck this is saying.

MR. STYKA: I don't think we can use a number, because as Mr. Goldman's example --

MR. HORWITZ: But it is clear that if it affects a few, --

MR. STYKA: It could.

MR. HORWITZ: -- it is a conflict; the word "few" to be later defined by specific situations.

MR. STYKA: I think it's still got -- no matter what we write, it's going to be a situation by situation decision.

MR. HORWITZ: But it's not only one?

MR. STYKA: Yes.

MR. HORWITZ: Then I would just suggest that you put that in there.

MR. CHRISTENSEN: The troublesome word is "exclusively." If you say "benefits," as opposed to "exclusively," or "benefits directly," but not --

MR. STYKA: That "exclusively" is the only way to prevent all of these commissioners from being excluded from virtually everything.

DR. SANDLER: I think that we can rely upon Mr. Styka's advice on an issue per issue basis.

MS. TURNER-BAILEY: I would like to --

DR. SANDLER: Objective advice is not -- he's our lawyer.

MS. TURNER-BAILEY: I would like to proceed along those lines. At least until we determine it can't work that way, I'd like to --

DR. SANDLER: We'll just take his advice when there's a conflict.

MS. TURNER-BAILEY: Okay. So January 25th is the deadline for getting your suggested changes to the bylaws. And that would be, you know, things that we haven't already discussed today, unless you want to revisit something. I guess we could do that. Get those to Brenda, please, and she will forward them to Mr. Styka and he will incorporate them and get them back to us before February 8 -- or by February 8th, which would give us the 30-day -- the mandatory 30-day time period to review so we can vote and hopefully adopt them at the March meeting.

MR. STYKA: Now, I always hate doing this. But just if somebody on the 28th or 29th of January thought of something, as long as they got it to everybody by the 8th, it would be okay. It just wouldn't be part of my package that I would give you.

MS. TURNER-BAILEY: That's fine. I'm just asking everybody to cooperate in that. Because -- and I chose two weeks to give you plenty of time to get the changes. Okay. Thank you very much. We appreciate your work, and Mr. Hart and Mr. Goldman, as well.

MR. STYKA: And, again, as I said before he came in the room, Bill Hart is responsible for a lot of the initial drafting of this. We appreciate that.

MS. TURNER-BAILEY: Thank you very much. The next item on the agenda is the surgical services workgroup. Commissioner Hagenow generously volunteered to serve as the Commission liaison. Commissioner Hagenow?

MS. HAGENOW: Yes. And maybe we can catch up some of our time here, because I will say to you that we started this late spring, early summer. And it's new to me to be a liaison. Our workgroup is an informal workgroup. The idea was to -- it's upon the queue for reviewing and that we would review it, with a constituency kind of representation. And perhaps it was going to be fairly easy. Well, we found out after five meetings of the group that it was not simple -- just revision of the surgical standards. In other words, we didn't just have to change the micropolitan and the metropolitan, there was some really significant issues. And I think the primary reason there are so many issues on this is because surgery is moving to ambulatory sites and has now become a niche market. And so it's a much bigger deal than just taking the old standards and saying, "We've reviewed them, they're up to date, and here we are, ready to present to you today." That was our thought in the beginning, that we could perhaps go fairly quickly since we had a very good workgroup representing MHA, Ambulatory Surgery Associates, doctors groups; a small group but very constituency representation. But that clearly has -- by the last meeting we decided that what we needed to bring you here today was an update on exactly where we're at, and then request the Commission to charter a fact group for some particular touchy issues that we think will make it a much more -- under the Open Acts laws and so on that it can be confirmed with the right and proper process that needs to be in this procedure. What we found in the standards language was, it was easy to add the provision around Medicaid participation. Even though ambulatory surgery sites are not reimbursed, it still should be a requirement that it is in their language because as it moves along, undoubtedly there will come a point that Medicaid will probably reimburse there. So that needed to be added. We also found that as acute care settings have moved now to 70 percent of our -- even more -- 70 to 80 percent of their inpatient surgery is done as an ambulatory procedure, that there needed to be a different volume compliance. And that was fairly easy to

take the old data for using cases or for using minutes or procedure time -- that was fairly easy by using a weighted average and allowing that to happen. So we got through that part fairly clearly; not a big difficulty to be able to differentiate and to allow for volume using the same criteria that had been used before, but allowing it to be a weighted one so that whichever category it was in, it could be satisfied as a volume requirement. The language around open heart surgery services, when they have to hold it on standby for cardiac cath and basic cardiac cath procedures, that's clearly an allowable time, much as you see in the standard currently for dialysis. So we got through all of that. So what was it that we got stuck on was the definition of "surgical procedure." The big difference and nuance is that it is not just inpatient and ambulatory, but now it's doctor's office. And what can be defined as a surgical procedure wasn't all that easy. We looked at the Medicare rules and regulations on how they are defining, which is largely ambulatory or inpatient kind of status. But we look at anesthesia, and you see there are standards under the anesthesia association for what needs to be in the requirement. And what we really determined is that we need a definition. And we could not come up with one that mutually agreed with everyone in the room. An example would be a mole. There is a code for that under Medicare. But should -- does the definition define that it can be done in the doctor's office, and can now be used in an ambulatory site as a volume? Even though before it was done in a doctor's office, can it now be defined as a surgical procedure to meet the volume requirements for a surgery center? Well, you can see that becomes a very big issue. There were two others that I think are lesser issues. But the big one is that we need a SAC around this definition because I think it will solve a lot of problems if we can clearly have criteria, much as the bed needs say, "Here's the criteria, and we're applying that, and here's the result." So that's the biggie. But the other two were whether or not to waive the volume requirement for the facilities under the same ownership when relocating operating rooms within a two-mile radius. Same ownership within a two-mile radius, do they have to now satisfy the volume requirement, or if they find that if they move to this site less than two miles away where there is a better patient flow that they could more likely achieve the volume requirement, or do we open it up and say, "No, they don't have it," and if they haven't demonstrated it in this site, they have to go through the criteria in the second site? And the third one is rural adjustment. They want more time to be able to achieve the volume requirements that are in the current standard. So those were the -- what I would say at this point is the charter to review what we have already concluded and the language is in here for that which we found a pretty successful conclusion. So you would say that this team will have a jump-start, because there was a clearly representative group that came up with conclusions. We could agree to that. But these last three, that -- we need a group that would be meeting and having open participation, having hearings, and be able to do it in a very solid process so that when we do approve it, it will be approved and -- with, I think, more substantiation than doing it in the informal workgroup.

MS. TURNER-BAILEY: Commissioner Ajluni?

DR. AJLUNI: Would a motion be in order, Madam Chairperson?

MS. TURNER-BAILEY: I do have a couple of cards for public comment. Would you mind holding your motion?

DR. AJLUNI: Sure.

MS. TURNER-BAILEY: Amy Barkholz?

MR. MAITLAND: While Amy's walking up, is it your intent just to hold those recommended changes that you have a problem with until the SAC meets and –

MS. HAGENOW: That's the intent so that we don't have to have it go to the legislative and have a public hearing and then have another round, so that when it's all done, it would be all done.

MS. BARKHOLZ: Hi, I'm Amy Barkholz from the Michigan Health and Hospital Association. I was able to participate in these informal discussions. I would only say that on behalf of the MHA, we support Commissioner Hagenow's recommendations for these issues to go to a Standard Advisory Committee. We also support the consensus issues that the workgroup developed and hope that the SAC would consider those as some work already accomplished. And, actually, we would like to thank

Commissioner Hagenow for helping to facilitate this, because I think hopefully it will cut down on some of the workload for the SAC. Thanks.

MS. TURNER-BAILEY: Thank you. Any questions? Comments? (No verbal response)

MS. TURNER-BAILEY: Robert Meeker?

MR. MEEKER: I'm Bob Meeker from Spectrum Health. And I would like to address one of the issues of consensus and add emphasis to it. The requirement that surgical centers be required to participate in the Medicaid program, I would strongly urge this Commission to do whatever it can to require the Medicaid program to contract with surgical centers, because it is an anomaly where if reading the law strictly, a surgical center could never be in compliance with their CON because the -- Medicaid will not contract with them. We've had a situation in Grand Rapids where a private surgical center for ophthalmology services approached Medicaid and said, "We would like to take our fair share of Medicaid patients. We don't expect significant payment, but we would like to cover the costs of the materials needed for the patients that we treat in our surgical center." And Medicaid said, "We're just very" -- I'm paraphrasing, obviously -- "We're very glad that you'd like to take care of our patients. We will not pay you anything. We will not have an agreement with you for payment." And I think that here's an example of a surgical center -- a private surgical center that wished to step forward and accept its fair share of patients and was prohibited from doing so. And speaking now as a hospital representative, there are a lot of private surgical centers that perhaps don't want to do that, which puts, then, an unfair burden on the hospitals. So I think that this is an extremely important requirement, that it needs to be a fair playing field for all providers of surgical services, and Medicaid needs to step up and make sure that they will allow and require surgical centers to take their fair share of patients.

MS. TURNER-BAILEY: Do you have a question, Dr. Sandler?

DR. SANDLER: I'll let it go for the sake of time.

MS. TURNER-BAILEY: Okay. Any questions? (No verbal response)

MS. TURNER-BAILEY: Thank you. Commissioner Ajluni, your motion would be in order now.

DR. AJLUNI: My motion would be that the chairperson appoint a Standard Advisory Committee to study the issue of the surgical services workgroup as outlined by Commissioner Hagenow.

MS. TURNER-BAILEY: Is there support?

DR. YOUNG: Support.

MS. TURNER-BAILEY: Support by Commissioner Young. Discussion?

MR. GOLDMAN: Yeah; I have just one brief question. If I understand, we're not going to approve any of the recommendations today, we're going to wait for the reply. Thank you.

MS. TURNER-BAILEY: Any discussion? (No verbal response)

MS. TURNER-BAILEY: Now, the question of the charge comes at this point. We haven't passed our bylaws which would allow us to sort of have a general discussion now and then the chairperson go and come up with a charge. And Ron's gone, so I don't know if we can actually even do that, before we pass the revision to the bylaws. Commissioner Goldman?

MR. GOLDMAN: If this motion passes, it would be my intent to then move to have you, with the vice-chair, craft a charge on behalf of the Commission. We've heard the elements of the charge, and now the question is a drafting question. So that's what I would do. I think you are -- I am allowed as a commissioner to make

that motion. If it is seconded and approved, then we've delegated responsibility for drafting the charge to you.

DR. YOUNG: Excellent point. Seconded.

MS. TURNER-BAILEY: Okay. So we'll vote on the first motion first, unless you plan to amend -- were you planning to amend your motion, Commissioner Ajluni?

DR. AJLUNI: No. I just was going to say that the maker of the motion was comfortable with Commissioner Goldman's comment.

MS. TURNER-BAILEY: So those -- all those -- hearing no further discussion on the motion, all those in favor please signify by raising your right hand. ALL: (Affirmative response)

MS. TURNER-BAILEY: It's unanimous. Did you have a motion at this time, Mr. Goldman?

MR. GOLDMAN: Yes. So given the fact that we've had a nice presentation by Commissioner Hagenow, that we understand the elements of the charge, that we've discussed them as a commission, I would move to delegate the actual drafting of the charge to the chair and vice-chair of the Commission.

MS. DEREMO: Support.

MS. TURNER-BAILEY: Moved by Commissioner Goldman, support by Commissioner Deremo that the Commission delegate the work of drafting the charge along the lines and consistent with Commissioner Hagenow's report. Any discussion? Brenda?

MS. ROGERS: This is Brenda Rogers. Just for clarification, does that -- this motion mean that you will bring the charge back to the next meeting? Or will you be soliciting nominations and moving forward?

MS. TURNER-BAILEY: Prior to the next meeting?

MS. ROGERS: Right.

MS. DEREMO: My understanding is we would be soliciting nominations prior to the next meeting and that we would be moving forward.

MS. TURNER-BAILEY: Okay. Any further discussion? Questions?

MR. MAITLAND: This is Maitland. I hate to be difficult, but is Norma on there because she was representing our commission with the group, or as vice-chair? Because if I was the one advising the group, would I would with the chair --

MR. GOLDMAN: Yes.

MR. MAITLAND: -- do the charge? So she's not on as vice-chair, she's on as the representative of that workgroup?

MR. GOLDMAN: No; what -- I'm sorry. I should have made that clear.

MR. MAITLAND: Okay. That's what I thought.

MR. GOLDMAN: But the point of my motion was not as -- not in her position as vice-chair, but in her position as the liaison to the --

MS. TURNER-BAILEY: The liaison.

MR. GOLDMAN: -- for those standards; yeah.

MR. MAITLAND: Thank you.

MS. TURNER-BAILEY: Okay. Any other discussion? (No verbal response)

MS. TURNER-BAILEY: All those in favor, signify by raising your right hand. ALL: (Affirmative response)

MS. TURNER-BAILEY: Okay. That's 10, with one not voting. Thank you, Commissioner Hagenow. We appreciate your work that you've done to date.

MS. HAGENOW: I learned a lot in the process.

MR. HORWITZ: Madam Chairperson?

MS. TURNER-BAILEY: Yes?

MR. HORWITZ: If I just -- the prior practice of this Commission has been to allow the chair to appoint commission members -- to appoint advisory -- ad hoc committee members with the members of the Commission asked to by two weeks after the given -- to send in names. If you don't, if you have to wait until the March meeting, then this surgical advisory process which has been going on for a long time, which people thought Ms. Hagenow's group would then come to closure by this time -- now we have to -- it's going to just add three more months to the process.

MS. TURNER-BAILEY: We just agreed to appoint the members before the March meeting.

MR. HORWITZ: Oh, you did?

MS. TURNER-BAILEY: Yes. That was the motion.

MR. HORWITZ: Thank you.

MS. TURNER-BAILEY: New medical technology?

MS. ROGERS: Again, this is Brenda. Nothing to report.

MS. TURNER-BAILEY: Thank you. Compliance report?

MR. CHRISTENSEN: This is Jan Christensen. We have two items on the compliance report. One relates to the open heart -- (Off the record interruption)

MR. CHRISTENSEN: The first issue relates to the open-heart program. As the commissioners now, we have C of N standards for open-heart programs that require a certain number of procedures be undertaken in order for a program to be in compliance on an annual basis. We have actually three different standards for the 32 or so open heart programs in the state. And it largely reflects the evolution of the standard over time. Initially there was no standard, so there was a whole series of programs that have no base limit standard they have to meet. Then we adopted a standard of 200 several years ago, and so there were a series of programs that were approved under that standard. And they have to meet 200. Then that standard was revised up to 300, so we have a series of programs that have to meet the 300 standards. That history puts us in the somewhat awkward position of trying to do a compliance action against a standard where we have programs that are functionally required to hit different targets. But as we looked at that, we have essentially -- of the 32 programs, we have five hospital programs that are out of compliance with that standard in the state. We -- the standard also included a period of time where you could be phased in over a series of years where you could build up to the standards. So you weren't immediately required to hit that standard. But of the ones that should be hitting their target standard in the approved, we had five programs that are not hitting that standard. We have three-year running totals on those programs and most of these programs have not been hitting the standards for the three years. We sent letters out to each of those programs in November, asking for a -- I think it was November 12th -- asking for a plan of -- first of all, do we

have the right data, is all the data being reported, or is this an artifact of the collection system that we have; and secondly, if it was real data and they didn't have more to add or updated data, what was their strategy for coming up to the compliance number that's currently in the standard? We expect that we will receive those reports back and we will have further dialogues with those five centers about their levels and about compliance and about when they intend to meet compliance, or what's their response to not being in compliance in terms of the regulation. So on the open-heart surgery program, in terms of trying to implement the existing recommendations -- or the existing standards that we have in C of N, that reflects our activity.

MS. TURNER-BAILEY: Commissioner Sandler?

DR. SANDLER: I had given a copy of this e-mail, which is only Sunday's e-mail, to Jan just prior to this meeting. What I did was -- this has been an issue I have some interest in, mainly for patient safety. And quite frankly, I questioned when we were discussing this last time, having three different standards, as to how we got them. But somewhere there has to be a clearer picture of this. So frankly, I took it upon myself to do some research about this. And I went to a well-known research site, Google.com, and I came across a 1999 article by Dr. Eagle as the lead author. He's the chair of -- chief of cardiology at University of Michigan, and he's the lead author of the ACC guidelines. And I recently heard a talk from him, so I e-mailed him. I also e-mailed Dr. Bates, who is the president of the Michigan Society of ACC, and said -- basically, the e-mail of my message -- my message says basically that, "If you were in the audience while we were reviewing this," blah, blah, blah, "what number is ACC recommending? I noticed you wrote in the article -- lead author in 1999, you recommended 200, you recommended 300, talked about outcomes. Are there peer review articles? Let's get a small amount of science behind this. He sent me back the following e-mail. In fact, incredibly, he sent it back to me first thing Sunday morning. I was quite surprised when I looked at that. Here's what he says: "The CABG guides were recently updated. We recommend 100 cardiac surgical cases per surgeon per year. Any program needs at least two surgeons so there are 200 per institution. While the CON currently has argued for a higher number, this is not currently supported, based on the data." That's his opinion. It's important to note that it is open-heart cases, not isolated CABG's, so basically we could count valid cases according to the argument. He is the lead author in the revised guidelines, which came out in 2004 for the ACC. So I looked them up. It's actually a 98-page document, but on page 61 -- and also, he now -- Dr. Bates, who said -- he also told me to look at those guidelines. Unfortunately, the guidelines are a lot more vague than his e-mail is. You really can't find a number in his guidelines that matches 200. He talks about high volume and low volume, and he talks about, "Gee, 100 -- anything under 100 you've got to look at suspiciously," but there is really not this -- here are my comments, having thought about this: It is very hard to justify 300 as a number. There is really nothing in the literature, there are no experts at the ACC that talks about 300. And in talking to Jan earlier, if a hospital has 280 and we're on their case about "Should you have a cardiac bypass program? and another hospital is doing 205 and we're letting them go along with that, it really doesn't make any sense. I believe based on what Dr. Eagle sent back, and based upon the ACC guidelines, a more practical number would be 200, period. I think the question is, is 200 the appropriate number? I have some suggestions only for the Commission to look at. Do we wish a new standard of 200? Because there's really nothing I can find that has -- I was actually quite surprised. I thought I was going to find 250 or 300, but I didn't. Another possibility would be a small workgroup in which we would ask cardiologists/cardiovascular surgeons/ hospital administrators to comment what they think would be appropriate. Now, in terms of politics, Eagle, by saying 200, is actually hurting the University of Michigan, not helping because the lower the number, the more competition you would have. So certainly he's acting in a very honest manner; same thing for Henry Ford. The lower the number -- the higher the number, the better off your referral center would be. Plus there's a geography issue; you have to be careful about shutting out places in the state for geography. Geography plays an important role. For example, Commissioner Maitland's home institution, Munson, does more cases than the University of Michigan does, as a matter of fact. What would the Commission feel is the next appropriate step? I don't think going after hospitals doing 280 instead of 300 makes any sense, however. I'll just throw out this additional information because of my own interest in this.

MS. TURNER-BAILEY: Commissioner Andrzejewski?

MR. ANDRZEJEWSKI: Jan, I'm just wondering, as a point of clarification, if you can give us some additional information about these statistics of those five hospitals. For example, were they all licensed under a

different standard? How far away are they from meeting the procedure requirements? Do some of them at least meet the requirements of the lowest standard?

MR. CHRISTENSEN: I can give you a little bit, and I'm fishing it off a bigger database. So don't hold it as 100 percent accurate, in case I transpose a number here. But one of the hospitals, the first one on the list in 2002, had 200 procedures, and had 242 procedures in 2003. And they were -- had a C of N under a standard that required 300 procedures. The next one is a hospital that has -- is under a 300 procedure. It had, in 2002, 91 procedures, and in 2003, 122 procedures. So there's an example where it's very far off. We have another hospital that was licensed under a 100 -- well, it was licensed under the 200 standard -- or C of N under the 200 standard, and it in 2002 had 219 and in 2003 has 156. And we -- when we sent our compliance letters out, we asked for quarter to quarter, year to date, 2004 data to see whether or not it's a momentary blip or a continuing trend in the thing. We have another one -- let's see. We have another one that has, in 2002, 181 procedures; in 2003, it had 146 procedures, and they were C of N under a 200 standard. So there are some that are close to their 300 standard, some that are not so close, and there are some that are close to their 200 standard.

MS. TURNER-BAILEY: Commissioner Ajluni?

DR. AJLUNI: I'm a little confused, Jan; maybe you could help me. Is the question before us do we want a uniform standard? Or are we locked into the hospitals that were approved without a standard as staying that way?

MR. CHRISTENSEN: I was not addressing the issue at all on compliance, with respect to a new standard. I think if we want to do that, we probably have to go to a workgroup or a Standard Advisory Committee of some sort to figure whether the standards are working and whether there should be a change. I was merely reporting under the compliance report. We're required to do compliance activity, and I was giving the Commission members an update that we're finally doing some compliance activity. We've been really -- and I'll talk more under the legislative side, we've been understaffed and we haven't had the resources in the last couple years to do the compliance activities that were required under PA 619. We have initially started to take some compliance activity -- and this is one of them -- where we have at least sent letters out to these particular programs and said, "You do not appear to meet the standard under which you received your C of N. Are we getting all the data?" -- first figure out if it's an artifact -- and then secondly, "If the data's correct and you're really not meeting them, then what are your plans? Are you expecting your numbers will go up? Was it a momentary blip in your numbers? Perhaps you lost key personnel and you can't -- you can't do it or something. What's the plan to do the correction to get the numbers up to the standards you met?" When we started taking a look at that, questions can be raised as Dr. Eagle and others have raised about what is the right number. And a good question Dr. Sandler is raising for the Commission is do you want to have a workgroup on it or SAC or should we just move forward on the -- the way we're going?

DR. SANDLER: I am arguing -- to respond, I'm the one who brought up the question of standards. Based on viewing the scientific literature, I cannot find a justification for the number 300 anywhere. There is some opinion for 200, but there's really no -- I have one other comment. I reviewed the data from September. The original hospitals that didn't have a CON standard, they're all the large hospitals in the state. They are way above 300. They're at 4-, 5-, 600; they're Beaumont, St. Johns, Michigan. They're way above that. Those aren't at the issue anyway.

MS. TURNER-BAILEY: Commissioner Hagenow?

MS. HAGENOW: I think it is an issue of three things; cost, quality, and access. Because -- and the practice is changing. In other words, as we have more and more invasive cardiology, we're going to have less and less of cardiothoracic surgery. So therefore, the volume may, indeed, go down. And that then gets to the quality issue. And I didn't think it was so much that their expertise was there, but that the literature does correlate increased mortality if you get to below a certain number. I mean, I've read those researches on outcome mortality. And I know there's case mix index and all that sort of thing. And I'm not necessarily wanting to argue about it, but just to say that I think -- and then if you go down too low in volumes, then you're going to get to the access issue. But that can drive up the cost, because everybody's got to maintain fixed costs for something that they're doing such low volume. So I would espouse that it is complex, and it is

changing, and that we put it into the cycle. I mean, we've got quite a few SAC's coming off here right now. But we should put it into the cycle to get it reviewed, and that gives the guidance for them for the compliance. But I think it's commendable you're getting on with compliance, because there is nothing to this if we just keep setting things and then we never follow through on it. So I think it should just be cycled in.

MS. TURNER-BAILEY: I would like to make a recommendation that we allow for the completion of the compliance report, the work -- we have the legislative report and then the work plan discussion comes up right after that. And I think that's an appropriate place to think about where all these things will fit, because then we can look at where we are relative to Standard Advisory Committees -- we've talked about two already today. We've got a third one that's coming up -- just to make sure that we're thinking about our priorities with a complete picture. But that's my suggestion. So if everybody's okay with that, I would just ask Mr. Christensen to complete his report. (No verbal response)

MS. TURNER-BAILEY: Thank you.

MR. CHRISTENSEN: The second major issue on compliance dealt with an organization in Clinton Township that was attempting to operate a program without a C of N. Some of that material's included in your operation. The goal was -- I think their goal was to ultimately open a hospital in what would be considered trust land for Native Americans and to attempt to, I think, avoid the C of N requirements under that agreement. In November, the director of the Department sent a letter out to all payers in the state reflecting the C of N requirements in our statute that basically say that, "You have to have a C of N if you want to get paid for the services you're delivering" and notifying the third-party payers that, in fact, they didn't and they should be very cautious about paying. The second thing we did was further investigation; sent individuals down from the Bureau of Health Systems and the C of N program to review some of the things in the program to see what was actually happening. The results of that are included in the affidavits that you see supporting it. And then the final thing we did was send out a compliance order, basically suggesting that they needed to cease and desist since they were not a legally authorized organization in the state. We got virtually no attention from them until we sent the order down saying cease and desist. We were prepared and worked in good office with the Attorney General to go into court to seek an injunction if we needed to, but we wanted to see what would happen with the cease and desist order. And based on that, the Attorney General and our legal staff were able to work out a consent agreement where they agreed not to do it, and also agreed in one of the stipulations if they ever decided to transfer land into trust to Native American tribes or groups, that they would notify us in advance of that so we would have the opportunity to be aware of whatever's happening. So we think that has closed that off, at least temporarily. These kinds of schemes pop up periodically, but I think we were very aggressive in protecting the C of N statute in the state and with the assistance of the Attorney General, we were able to close this one down.

MS. TURNER-BAILEY: Any questions? Thank you. The legislative report? Oh, I'm sorry. I had a card. Is that --

MR. HORWITZ: I can wait for the workgroup.

MS. TURNER-BAILEY: Okay. The legislative report? Can I just make a comment? I'm sorry. I didn't mean to interrupt you. But just to keep -- just to sort of keep everybody aware of the time, it's 2:35. We have a scheduled end time of 3:30, and I have at least two commissioners that said they need to leave at 3:30. So I'm going to ask everyone to try and be expeditious in their reports and discussions. You can take as much time as you want, just –

MR. CHRISTENSEN: With that caveat, very, very briefly, the legislative session closed last Thursday at about 11:00 o'clock. The lame duck sessions -- typically the last six days of legislative activity are quite intense. We had one major bill that we were interested in, Senate Bill 576. It raises the fees for the C of N program. It basically enacts a revenue source to support the activities that were first identified in 619 when it was passed. It suggested that there should be more emphasis on enforcement and compliance; more support for the Commission. These fee increases, as you look at the individual numbers, I want to point out to the commissioners that there's a subtlety here. The individual numbers look like they've doubled, so the average person would probably say, "Well, you've doubled the amount of revenue coming in." That is not correct. The revenue has gone up a little bit, enough to support the additional staffs that we need. It will

raise about 1.2 million in fees in the C of N program. But it isn't doubled, because what we did was we raised the thresholds as well. So when you do -- you pay a fee on an engineering program, it's so much if it's under 750,000. Well, we raised that threshold. And there's an other tier that says at 1.5 million, we raised that threshold to 4 million. So what we've done is we have raised the fees, but we've raised the thresholds for the projects as well so that we now have a relative balance of the burden of the fee for the small entities, the medium-sized entities and the large entities are proportionately paying about the same amounts of money in the fee for C of N services relative to the size of the projects. And that work was done by Larry and the C of N unit to balance that out. We did get support for the C of N legislation. I want to thank all the folks in this room because this is one of the issues that I think we're all on the same page on. And given the very conservative bent of no taxes and no fees that seems to permeate the air these days in Michigan politics, it would not have been possible to get that necessary fee without the collaborative effort of everyone, and a lot of the folks in this room that worked hard down there in the legislature. We did have -- just to finish this report up, we did have a number of people that thought -- because this is a bill that amends the C of N section of the Public Health Code, thought this might be a good opportunity to tack some stuff on to it that might be helpful to either exclusive or not so exclusive individuals or programs around the state. And I can say without fear of contradiction there was unanimity among the leadership in the House and the Senate, and in the Executive branch that these were not appropriate vehicles, that we were not going to do any legislative tweaking in lame duck. And a series of amendments were offered, none of them had enough support to carry, though, and the fee bill came through clean, again, thanks to a lot of the collaborative efforts between the various hospitals, the Economic Alliance, the various interests, nursing home groups and others that were in support of the appropriate funding for C of N. Without it, we would have had a $600,000 hole in the program and would not have been able to add the additional compliance duties that were envisioned and Commission support duties that were envisioned in 619.

MS. TURNER-BAILEY: Thank you. Are there any questions? (No verbal response)

MS. TURNER-BAILEY: The next item on the agenda is the review of the Commission work plan. It should be something we have in our binders, I think, to have a visual look at here. Brenda?

MS. ROGERS: All right. You should have a copy of the work plan in your binders, so I'll quickly go over that. And then we can talk about any modifications needed to the work plan. Hospital beds, as you took action today -- you've taken a proposed action so we will schedule a public hearing for that for sometime in January but prior to February 9th, to meet the time frames to take final action in March. MRT is on the work plan, and I know, Renee, you're going to be talking about that shortly and that remains on the work plan. Nursing Home & Hospital Long-Term Care is now removed. Those standards recently became effective December 3rd and now are posted on our website. And I believe we brought copies today that should have been on the back table, and we provided copies in the binders for the commissioners as well. PET remains on the work plan. Again, according to the standards, those need to be looked at and reviewed and updated, so that remains on the work plan. Surgical services will remain on the work plan as the Commission approved today. We will be looking at putting together a SAC for that workgroup. New Medical Technology remains as a standing item. PA 619, 2002, remains as a standing item. The CON annual report for fiscal year 2003, unfortunately we don't have the copies today, but the draft has been completed. And so we hope to have the final copy to you at the March meeting or prior to the March meeting. One other item, it's not on your work plan but, again, as you talk about modifications, as most of you know, under the statute there is a requirement that a report be submitted to the legislature in January 2005 as far as its recommendations on the program. So that may have to be added to the work plan.

MS. HAGENOW: And that open heart surgery?

MS. TURNER-BAILEY: You have to make a motion on that.

MS. ROGERS: That hasn't been decided for sure yet.

MS. HAGENOW: That's for us to do that at this time, after --

MS. TURNER-BAILEY: Right.

MS. HAGENOW: -- we get -- okay.

MS. TURNER-BAILEY: Right. Any questions about the work plan as it stands? Commissioner Goldman?

MR. GOLDMAN: I've got a quick question, Brenda. The question of psych beds that we were going to get some public comments on and that there was a tab in here, what's the status?

MS. ROGERS: That's later on the agenda. At that point in time, once the Commission has heard the testimony, if you decide to take action and then want to further modify the work plan at that point, that would certainly be appropriate.

MS. TURNER-BAILEY: How many SAC's can we have going at one time? It's been awhile since we've asked that question, hasn't it? Just what do you think relative to staffing that makes senses? We won't hold you to it; just give us an idea.

MS. ROGERS: Given the six months time frame for each of these SAC's until we get additional staffing, I -- you know, we will do our best to accommodate.

MS. TURNER-BAILEY: Okay.

DR. SANDLER: Can I comment on that? There's some issues that I don't think need a SAC. The PET would be one that really there's a few technical issues that my suspicion is doesn't adjust for the volume or the ease of getting a PET scan. So my suspicion is that it would be like the MRI in the rural areas, one meeting and all the stakeholders being present -- probably can come back to the Commission without a SAC. And even this open heart -- basically the concern I have is the number involved, not whether or not it's justified. We all know that open hearts will go down in the United States because -- I don't think -- know if that needs a SAC. It needs a work force to recommend to this commission.

MS. HAGENOW: So an informal workgroup?

DR. SANDLER: Informal workgroup. It doesn't have the complexity of the hospital beds.

MS. TURNER-BAILEY: What one are you talking about? Which one are you referring to?

DR. SANDLER: To two of them, PET and the question of cardiac bypass, the number needed for the program to be in compliance. We are basically going to ask one question, what is the appropriate number for the geography? But geography doesn't even appear to be the big issue here. The big issues appears to be what is -- in the modern era, based on what's in the literature, what's the appropriate number?

MS. TURNER-BAILEY: Brenda?

MS. ROGERS: Renee, just to keep in mind that -- and I agree. Some of these issues may not require a formal SAC. But even in putting a workgroup together, if you want staff participation, that still comes -- has to come under consideration. If you want to put a workgroup together and work on it within that workgroup not expecting necessarily having staff support there, I don't see that as being an issue, because you are allowed that under the current statute. But just keep that in mind.

MS. TURNER-BAILEY: I think it would be -- those commissioners who have served as liaisons so far can contradict me, but it seems to me it would be difficult to do without staff support, I would imagine, in pulling together meeting locations, calendars, et cetera. So I think we should just keep that in mind, that it's not -- just by saying it's not a SAC, that doesn't mean we don't need the staff support. That's --

DR. SANDLER: It does mean, though, you aren't going to appoint a whole bunch of people and have -- that's what I'm trying to –

DR. AJLUNI: Well, you have your Open Meetings considerations, too.

MS. TURNER-BAILEY: Well, we have to have that question answered.

MS. HAGENOW: That was where I was going to comment. The informal workgroup -- I think you can get a lot of the science together. But the open process that it has to go through to be able to know that you're going the right -- you're doing the right health policy thing, you have to hear dialogue and so on. So it becomes closed or open. And I think that's kind of significant, too.

MS. TURNER-BAILEY: My thought is if we were doing something as serious as changing the standards, even if it seems logical to everybody, we should go through the bigger process. That's my own opinion. Simple language changes, that's one thing. Commissioner Andrzejewski?

MR. ANDRZEJEWSKI: I guess I just wanted to question this PET scan thing and protocol, I think, necessary for its use. You're talking about technology that costs three to four times an MRI. And if we use it for defensive medicine, somebody's got to answer the question, does it get used in place of an MRI, in addition to? You know, you've seen what happens with CAT scans and MRI's, and now PET scans. And the cost is just tremendous. So who's to answer the question when and how it's used and under what circumstances?

MS. TURNER-BAILEY: So you're saying it's not as simple as that?

MR. ANDRZEJEWSKI: That's my point. It's more than a number.

MS. TURNER-BAILEY: I actually agree with you. I have some cards for public comment. I know we've already had discussion on several items that we think -- I think we've already agreed need to be added to the work plan. I would ask the commissioners to, you know, continue to think that through as we listen to our public comments, because I will take motions right after that. Larry Horwitz?

MR. HORWITZ: The Economic Alliance has long had a particular focus on open-heart surgery. We publish every year or so a listing of every hospital in the state as to how many procedures they do on open-heart surgery. We've done it for about 10 years. So I'm rather familiar with this. Let me cite the following journal references: The basis for 2- to 300 was the report of the American College of Cardiology. It was published in the early 90's just before this commission took action, when it recommended 2- to 300, and indicated in there that it was making that variation to allow for the fact that there are sparsely settled areas in the country; for example, Montana, and so forth. Your predecessors at that time decided that Michigan was not a -- in the category of Montana and Idaho and Utah and therefore opted for 300. More recently -- and I'm not sure of this, but in either in the Journal of the American Medical Association or the New England Journal of Medicine, they did a -- published an article that did an overall review of all -- many, many studies and reviewed all the different suggested volume minimums for a whole series, and identified what they thought was the lead document. And the one that was done on open heart surgery identified 300 as the minimum -- very recent article. The Federal Medicare program has established recently a "Centers of Excellence" program and it has established 500. This is not an easy -- this is not a simple matter of just plain numbers. To the extent that you lower the minimum, you then are going to increase the number of programs that will exist. A program that wants to come into existence and compete with current programs has to project a certain volume under rather strict guidelines of past history. If you lower the number from 300 to 200, then you are very -- without question going to increase the number of programs. If you increase the number of programs, you're not going to increase the number of -- amount of cardiac disease. These increased programs are going to draw volume away from other places so that what you're then going to do is decrease the average volume across all programs. All the literature seems to suggest that higher volume does correlate with a very significant factor of quality, which is lower death rate within 30 days after surgery. It is said that it also has a correlation with health status even beyond that, so that we would strongly support and have consistently supported the 300 minimum. We do think there is past and ongoing support in the literature. Possibly a source of confusion here is when Dr. Sandler mentioned -- he talked about physician numbers. This is a quite different question. The physician numbers, 100, 75, 50, are the surgeon or the cardiologist minimum. That's a different question I think Eric is going to speak to than the facility volume. The compliance effort here was on facility volume. I think it would be a terrible signal for this commission after being admonished and the Department admonished by its auditor general that you have not been enforcing this long-standing minimum volume of 300, following the very few months of finally monitoring and enforcing your 300 minimum, to now decide, "We'll lower the bar." It's not going to make a huge difference.

Of the 32 programs we have in the state, all but six or seven are above 300. This is not a difficult or burdensome number to meet. This is not a question of remote rural areas having a hard time meeting this number. The places that are not meeting them are in the middle of our metropolitan areas. The names were specified by Larry at the last meeting. So St. Joe Macomb, which is in Mt. Clemens, obligated to meet 300, is down somewhere in the middle hundreds. Bay Medical is down in the low 200's and it's way beyond its first three years. Sinai, which is in Detroit, is supposed to have 300, it's down in the hundreds. So I think it would be –

DR. SANDLER: Grace Sinai.

MR. HORWITZ: All I'm trying to say is that there is significant medical literature. There are a lot of people in the field who think this is a valid number. It has been accepted by esteemed journals and everything else and would think this is not an area that needs significant attention. I do think it would be a terrible signal that once you start enforcing something, you lower the bar. So I would urge you -- so it's both a comment on the enforcement as well as on your work plan.

MS. TURNER-BAILEY: Commissioner Sandler?

DR. SANDLER: Here's my problem with what you said, Larry. I couldn't find any evidence to support what you said.

MR. HORWITZ: I'd be glad to send you the actual articles.

DR. SANDLER: I looked. I was quite surprised not to find anything that said 300 on it. But the -- Dr. Bates, who's the president of the Michigan Society of ACC, he can comment on this. The ACC, American College of Cardiology, 2004 guidelines, doesn't mention a number like that. And if it said 300, I wouldn't be having this discussion.

MS. TURNER-BAILEY: Commissioner Deremo?

DR. SANDLER: That's the problem.

MR. HORWITZ: We at least found one in the AMA Journal, or the New England Journal of Medicine in the last few years.

MS. TURNER-BAILEY: Commissioner Deremo, before you start your comments, I want to ask Dr. Bates -- I have a card from you specifically on CABG. So if you'd like to come forward I'd appreciate it, while Commissioner Deremo's asking her question.

MS. DEREMO: I was not going to ask a question. I was going to make a comment. And I do think that as a Commission, we have to look at the difference between the number of procedures a surgeon needs to have -- to do in order to be competent, versus the facility itself. Because when you're talking about an open heart surgery program, you are talking about a cadre of individuals besides the surgeon; anesthetists, you've got the open heart machine itself, you've got cardiopulmonary technologists, you've got nurses. And all of those have to have enough volume in order to remain competent. As I understand the 100 procedures per physician –

DR. SANDLER: Per surgeon.

MS. DEREMO: -- per surgeon, that is really basically two a week, if you assume that they're going to have two weeks off for vacation. But two a week is not enough to keep an entire unit, in my experience --

DR. SANDLER: It would be four of them, if you've got two surgeons.

MS. DEREMO: Well, if you have two surgeons, it would be four a week. But still, that really is very limited.

MS. HAGENOW: But when we look at a facility, we're looking at a team. But a surgeon may be working at multiple sites. You take Saginaw with St. Mary's or Covenant, and so on and so forth.

MS. DEREMO: That's my point, because what will allow a surgeon to be competent versus what will keep a facility competent I think are two very different questions.

MS. TURNER-BAILEY: I agree. Dr. Bates?

DR. BATES: Yes; my name is Eric Bates. I'm representing the American College of Cardiology, which is a professional organization in the state for the 600 cardiovascular specialists and now nurse practitioners and physicians' assistants. I don't think you're going to solve this question today, but I just want to clarify a couple of points that have been knocking around the room. The first is when Larry quotes papers, the papers represent the opinions of the authors. They don't represent the journal's stand on this issue, nor do they represent the position of the American College of Cardiology. As Mike and I looked at this document on Sunday, in fact the American College of Cardiology takes no position on volume standards for coronary artery bypass graft surgery. There's nothing in there that says you have to do 100 or 200 and 300. Dr. Eagle's comments represented his own personal opinions on the subject. And when we write guidelines, most importantly, they aren't meant to be used as regulatory numbers against which physicians and hospitals are supposed to be graded by government. They're goals to reach for -- they're based on the literature that does suggest that if you do more, you do better. But it's a very complex issue on patient selection and number of years doing the procedures, cumulative things and lots of other issues. If you decide to ascribe to -- to discuss this further, let me give you some good news. And that is that 31 of the open heart bypass surgery programs in the Lower Peninsula, they are all voluntarily participating in a database sponsored by the Society for Thoracic Surgeons, which I believe is led by Richard Prager of the University of Michigan. They share process of care ideas, they have meetings, they have private outcomes they review. And my understanding about talking about this issue with him is that those five hospitals actually have pretty good outcomes. So rather than just focusing on numbers from a regulatory standpoint, if you decide to discuss this further, I think you ought to include Rich and his input on what really is important, and that's process of care and morbidity and mortality rates.

MS. TURNER-BAILEY: Any questions -- one moment, Dr. Bates. I think we have some questions. Commissioner Ajluni?

DR. AJLUNI: Not specifically for Dr. Bates, just for Jan and the compliance people. Has a program ever been terminated for lack of numbers in this state?

MR. CHRISTENSEN: "Terminated" is probably not the right word. We did close a program related to a series of discussion with the program and an agreement that the program would close.

DR. AJLUNI: So one time it has?

MR. CHRISTENSEN: Yeah; that I'm aware of.

MS. TURNER-BAILEY: Any other questions? Commissioner Hagenow?

MS. HAGENOW: I just want to follow up with your point about the practitioner versus -- isn't it the CON's purview to be really looking at the facility and that you look at the hospitals themselves and the credentialing of the medical staff, and their annual review, look at outcomes and re-credentialing and so on? I just -- I'm questioning that we should just take off the table the individual, because I think there are other means of validating that, other quality review processes and that the purview or the domain here of the CON is really the facility that we've given the license -- or the authority or whatever it's called.

MR. CHRISTENSEN: If I may respond, you have really three different things that come into the nexus; quality, access and cost. That's the driver. One could argue that the quality of an open heart program is directly related to the morbidity and the mortality -- unnecessary morbidity and unnecessary mortality that the

program has or doesn't have. And so the issue would be, from a quality standpoint, perhaps to measure those kinds of outcomes.

MS. HAGENOW: By the facility?

MR. CHRISTENSEN: By facility. Now, we have in the current standards -- and correct me if I'm wrong, Larry -- a numerical count for individual physicians. But it's very hard to get that data.

MS. HAGENOW: Yeah. I don't think that's our purview.

MR. CHRISTENSEN: Because of the point that you mentioned, they could practice at multiple sites and how do you collaborate that back and how do you get reliable data and how do you know it's accurate. It's very hard data to get. So there does need to be, I think, some look at this. And I don't know where it fits on your work schedule, but it is an issue that needs to be looked at, at some point.

MS. TURNER-BAILEY: Bob Meeker?

MR. MEEKER: I'm still Bob Meeker from Spectrum Health. You've had a lot of cold water thrown on how easy it would be to change the -- or to revise -- make needed changes to the open heart surgery standards. I'd like to throw some cold water on PET. PET scanning has really just started to be implemented to any great degree in the State of Michigan. When the standards were revised a couple of years ago, there were only three PET scanners in the state. I don't know how many more have been approved since then, but they're just starting to come up into operation. In west Michigan we have a collaborative effort with -- between Spectrum Health and St. Mary's Medical Center. It has only been operating since September and already we're looking into the future and looking at the possibility, perhaps -- not this year, not next year but into the future, perhaps a second PET scanner because the volumes are so high, possibly the need to relocate or transfer ownership. None of those issues are addressed in the standards so that, you know -- as I said, these are not pressing issues for us today because we're just learning how to operate the service and getting referrals which we have been -- it has been a very heavily utilized service. And I think the oncologists in west Michigan are finding it an extremely good diagnostic tool and also a tool to help with staging of cancer. So it's something that provides a service that, as a layperson, I understand MRI and CT cannot provide. But my point is that I think that there are perhaps more issues that need to be addressed with PET. If this would be the first -- the only time we would open it the next three years, there might be some of those other issues that would need to be addressed as well, and it may not be as simple as we think.

MS. TURNER-BAILEY: Thank you. Any questions? (No verbal response)

MS. TURNER-BAILEY: Patrick O'Donovan?

MR. O'DONOVAN: My name is Patrick O'Donovan from Beaumont Hospital. I'd like to say that as it relates to the work plan, we would not recommend making any unilateral changes to the minimum open heart surgery standards unless and until a Standard Advisory Committee is appointed. In other words, we would oppose having it just changed through an informal workgroup. To support this contention, I was going to share this letter as it related to the cardiac cath standards, but it serves to make the point with regard to not making changes without a careful consideration of the volume requirements and a study of what those appropriate numbers are. And this letter is from our corporate chief of cardiology, Dr. William O'Neill: "It has come to my attention that a proposal may be made to the Commission that would eliminate the minimum physician volume requirements in the" -- "cardiac cath standards. While I agree that cardiologist volume measures are by no means a comprehensive indicator of quality and at times can even be misleading, such measures do represent one dimension of quality. Therefore, unless and until a properly constituted Standards Advisory Committee recommends otherwise, the existing physician volume requirements should remain in place. I have participated in such committees in the past and would be happy to do so again. I wholeheartedly endorse and support the Department of Community Health's efforts to enforce project delivery requirements for all CON review standards." Thank you.

MS. TURNER-BAILEY: Thank you. Any questions? (No verbal response)

MS. TURNER-BAILEY: Greg Dobis?

MR. DOBIS: My name is Greg Dobis, I represent McLaren Health Care out of Flint, and its subsidiaries, Bay Regional Medical Center, Lapeer Regional Hospital, Ingham Regional Medical Center, and McLaren Regional Medical Center. Two items I'd like to comment on is, first, the PET CT. McLaren was on the original -- way back, Dr. Sandler remembers, to get these new standards put in place. I do believe that many of the things that need to be done are technical in nature. We do need to move on into a more realistic situation with the PET CT standards. And one of the biggest issues, I think, is what's called the "80/20 rule," if you will, for lack of better terminology. And what it does, it really discriminates against systems who have hospitals in other planning areas. Right now, for instance -- let me give you a for instance. McLaren Regional Medical Center, on the PET route, is Lapeer, McLaren Regional Medical Center and Bay Regional Medical Center, all in the same planning area. Ingham is not. We are, by CON standards, only allowed to serve 20 percent of Ingham's patient base. It doesn't make any sense. It strips the economies of scales out of our PET network. And what we have to do is now look for another PET network that is not owned by the corporation, which means we cannot give corporate rates to Ingham Regional Medical Center to cover the rest of their patient population. It just doesn't make sense right now. So those are the type of, I think -- these are not major changes. They're just, I believe, technical issues. And I think we need to move forward. Either through a standing committee or non-standing committee, we need to do something. I think it can be handled in a non-standing committee arena. Maybe I'm wrong. The second issue I'd like to address is the open heart program. Bay Regional Medical Center is one of the hospitals that have been cited or given a letter, if you will, about the underperformance as it relates to volume. First off, I'd like to set the record straight. We are not around 220. This year we'll probably fall about 30 short of the required 300. We have submitted a plan of correction to Mr. Wheeler's office, along with all documentation, and we're hoping for a positive outcome. We think we can turn the program around, if that's what we'd like to call it, to get above the 300 threshold. But I do feel that because of the multiple 200 grandfathered and 300, there is some discrimination against some of the programs. And I think that needs to be addressed. I think we need to be all either under the same volume requirement or no volume requirement. And I also feel strongly that I would stack Bay Regional Medical Center's quality issues with 270 open hearts against any program in the state. I'm very confident; I do see those reports. Plus, secondly -- so I think it's probably a three-tiered thing which I've heard. One is quality. The second is that volume, and the third is access. And Bay Regional Medical Center is a sole provider in Bay County. So I think we have to look at all these issues and balance them out; not looking for any favoritism, but I think everyone needs to be on an equal playing field and different things have to be considered. Thank you.

MS. TURNER-BAILEY: Thank you. Are there any questions? (No verbal response)

MS. TURNER-BAILEY: James Ball?

MR. BALL: Good afternoon. James Ball, General Motors Corporation. I don't want to speak to open heart surgery, PET, any of those things. I'd like to speak to the issue of your decisions about whether to assign something to a workgroup or to a SAC. This is the second Commission meeting I've attended where Commissioner Hagenow commented on the group that she's had working or been liaising with on surgical services. And to my knowledge, I've never seen dates when those meetings take place, who's involved, where they take place, how somebody could be involved in it. And Dr. Sandler comments that he thinks instead of SAC's you ought to rely on workgroups where all interested parties are there. Well, I don't know that all interested parties are there. Something -- I think there's an Altarem (phonetic) report that recently that said over 80 percent of health care in this state is paid for by employers. I don't know that those payers were represented at those meetings and involved in those discussions. I don't know that any representatives of consumers or public interest groups were there. And so what happens if you have a workgroup that comes out with some product, and -- if you decide there's no SAC, then the first knowledge any of the rest of us have is when some draft standards are put on the table at a Commission meeting. And it's very difficult, then, at a Commission meeting, to comment about it. So then we have to hope to comment -- if you move the draft standards forward to public comment, we can comment there. But it's a rare public comment session, frankly, that any of the Commission members attend. So whatever dialogue or commentary or whatever goes on there, you know, may be lost unless it's captured in minutes, in its full extent, or people submit voluminous written documentation for you to wade through before your next meeting, and then, of

course, to try to appear at the final meeting. So I would just urge that as you go forward, if you decide not to go with the SAC approach, to go with the workgroup approach, to, at a very minimum, announce when and where those workgroup meetings are taking place so people can come, can sit in, can hear what's going on, and if they have some input to provide to that workgroup, have the opportunity to do so.

MS. TURNER-BAILEY: Thank you. Any questions? (No verbal response)

MS. TURNER-BAILEY: Are there any motions regarding the work plan?

MR. MAITLAND: I have one. I heard earlier that you were going to speak to MRT, which I thought we had in the process, and I thought would be half done. Where are we?

MS. TURNER-BAILEY: Well, if having the list of the appointees completed means we're half done, that's right. Because that was actually what I was going to say. We worked between the last meeting and this meeting, Commissioner Hagenow and I, along with the Department, and came up with a list of appointees for the MRT Standard Advisory Committee. We have that list here today. And if you're interested in looking at it, I think we would like to have the Commission's -- since this coincides with the Commission meeting, have you take a look at it and have your consensus on it. And at that time, we will ask the Department to help get the first meeting set up. We did have a meeting scheduled. Brenda –

DR. SANDLER: January 12th, wasn't it?

MS. TURNER-BAILEY: Is that still going to take place?

MS. ROGERS: (Nodding head in affirmative)

MS. TURNER-BAILEY: Really, the piece that needs to take place here is we really need a motion that helps to clarify the effective date of the appointment, which I would recommend would be January 12th. So that starts the six-month working time frame for this committee.

MR. MAITLAND: Is this list your recommendations --

MS. TURNER-BAILEY: Yes.

MR. MAITLAND: -- or do we have to narrow it down?

MS. TURNER-BAILEY: No. This is the recommendation.

MR. MAITLAND: Well, I'd move that these be the members of our SAC, and that the time start at the date of the first meeting.

DR. YOUNG: Support.

MS. TURNER-BAILEY: It's been moved and supported that we accept the members of the MRT SAC as recommended, and that the effective date of that appointment be that of the first meeting, which will be January 12th. Any discussion? (No verbal response)

MS. TURNER-BAILEY: All those in favor, please signify by raising your right hand. ALL: (Affirmative response)

MS. TURNER-BAILEY: Okay. It's unanimous. Thank you. Anything else with regard to the work plan?

MR. MAITLAND: Well, do I need to move that the chair appoint the chairman of this committee -- chairperson?

MS. TURNER-BAILEY: I don't know.

MS. DEREMO: I think you do that the last meeting, so you do have them do that; yes. But I think we need a separate motion.

MS. TURNER-BAILEY: We already agree that -- okay.

MS. HAGENOW: I think there is two distinct roles. The workgroup is closed focused trying to perk things up to be able to know whether -- if this is inconsequential and be approved by the Commission -- put out and be approved because it's not a big deal. But what we're running into is that just about everything we review is consequential. And that, then, requires the open process that the fellow from GM just spoke to, in terms of the SAC group. But maybe the way to look at it is that the SAC groups can work rather rapidly, as complex as -- the previous -- or most recent SAC group, they really had to deal with some meaty issues and they were able to do it. Now there's another one. But if we keep it -- I'm thinking that we need to have SAC's, and that the workgroup is just to try to get it focused enough to get it to know what the issues are. And I think it can take off some time from the SAC's. But the facts are going to have to be there. It just seems like it's just too consequential in terms of public policy to do it in a closed group.

MR. MAITLAND: I agree. I think these informal workgroups are just turning into the SAC's without legitimacy. You know, I -- when the legislature said we could do it without going through an ad hoc, I thought that was great. And it still might work if there's, like, one issue and it's changing a number from 10 to 9 and no one complains. But as soon as you open one of these up, we get 10 different issues. So I think we're really going to have to go back more to the SAC's and probably very few times we'll be able to do it without that.

MS. HAGENOW: Which means, I think, the question is how can we sequence it so that the Department can handle the facilitation with -- and if the liaison also works with it so that we can keep it going. I don't know. I think it's a operational issue.

MS. TURNER-BAILEY: Well, we have MRT. We're ready to start that mid-January. We -- I assume someone's going to make a motion to appoint a SAC for surgical services.

MS. HAGENOW: Yes, I would make that motion. Maybe we can get it out there, because it's got to be worked in here.

MS. DEREMO: Support.

MS. TURNER-BAILEY: Okay. It's been moved and supported that we create the SAC for surgical services. And that -- we actually have talked about this, but we're going to put it on the work plan. We're going to get the SAC and we're going to get the charge, and the members actually together prior to the next meeting. So the motion really is to put it on –

MS. HAGENOW: Oh, yeah, to put it on the work plan.

MS. TURNER-BAILEY: Okay. Yes, Brenda?

MS. ROGERS: Renee, this is Brenda again. Just for clarification in regard to the surgical SAC, do you at this point in time want to make a similar motion as far as the effective date of that surgical workgroup being the first meeting date? Do you want to do that at this point in time?

MS. HAGENOW: Yes. I think that's a good idea. Do you want to --

MS. HAGENOW: January 12th? No; I'm just –

MS. TURNER-BAILEY: Once we get the -- we'll put out a call for membership. Once we agree on the members and the charge, we'll set up the first meeting. And the motion that needs to take place right now is that the effective date of the appointment would be the effective date of the first meeting.

MS. HAGENOW: Okay. So moved; effective date is the date of the first meeting.

MS. DEREMO: It is supported.

MS. TURNER-BAILEY: I'm going to make that into an amendment to your first --

MS. HAGENOW: Yes.

MS. TURNER-BAILEY: -- motion so we can have one vote. All those in favor please signify by raising your right hand. ALL: (Affirmative response)

MS. TURNER-BAILEY: Okay. So we're adding that to the work plan. The other -- the second piece that I heard discussed today was hospital bed, that we need to create another SAC to deal with that. I don't know if we want to put that on the work plan today, or if we want to wait.

DR. YOUNG: M.S.U. couldn't get involved until this summer; is that right?

MS. TURNER-BAILEY: Right. So we can -- we don't have to develop that today. We can -- we can bring that up at a future meeting. Yes, Commissioner Deremo?

MS. DEREMO: I move that the second SAC for bed need methodology get on the work plan, the date to be determined based on the Michigan State University contract.

MS. TURNER-BAILEY: Okay. Is there support?

MS. HAGENOW: Support.

MS. TURNER-BAILEY: It's been moved and supported that we add hospital bed need to the work plan for future action. And we're going to tie that action to the point at which we have the support that we need from Michigan State and others. (Off the record interruption)

MS. TURNER-BAILEY: Any discussion? All those in favor, raise your right hand. ALL: (Affirmative response)

MS. TURNER-BAILEY: Okay. Any other --

MS. HAGENOW: I think we should request -- I don't know if it's ready for a motion today -- but this open heart surgery get into the queue. But let's have -- after the Department's been able to submit to us what they can do and what time line -- I mean, their facilitation. Sort of let them have a draft, but not to -- I don't know if that's a motion or not, but I don't want us to lose this. It's got to get into the queue.

MS. ROGERS: Just by adding -- again, this is Brenda. Just by adding open heart to the work plan, it puts it on there.

MS. HAGENOW: Okay. That's fine. I'm satisfied with that at this point.

MS. TURNER-BAILEY: All right. Is there a motion to accept the work plan as amended? Yes, Brenda?

MS. ROGERS: This is Brenda. I had a note -- okay. These will come later, cardiac cath and psych. But that's later on in your agenda.

MR. DELANEY: Move the work plan as amended.

MS. TURNER-BAILEY: It's been moved by Commissioner Delaney that we accept the work plan as amended. Is there support?

MR. GOLDMAN: Support.

MS. TURNER-BAILEY: Support by Commissioner Goldman. Any discussion? (No verbal response)

MS. TURNER-BAILEY: All those in favor, raise your right hand. ALL: (Affirmative response)

MS. TURNER-BAILEY: Okay. It's unanimous. Thank you. Future meeting dates: March 8th, June 22nd, September 3rd and December 13th of 2005. Please let us know if you have problems with those dates so we can make sure we have adequate attendance. Public comment.

MR. DOBIS: Excuse me. Could you repeat what was added to the work plan? We couldn't hear back here.

MS. BARKHOLZ: There are no microphones. They don't even work when you talk into them.

MS. TURNER-BAILEY: Oh. I'm sorry. Surgical services Standard Advisory Committee; we affirmed the appointment of the MRT Standard Advisory Committee to begin January 12th -- effective January 12th. We added -- there was one other that we added. Oh, the hospital bed need Standard Advisory Committee, we added that to the work plan. That will probably not get formulated until spring or early summer when we can use the services of Michigan State. So those were the three things we added to the work plan.

MS. ROGERS: The legislative report?

MR. HORVATH: 2005 legislative report is added to the work plan, too.

MS. TURNER-BAILEY: Okay. And the 2005 -- I'm sorry. The January 2005 legislative report is added to the work plan as well.

MS. HAGENOW: And the cardiac review, but we didn't set anything yet for action. But we did set -- add it to the list.

DR. SANDLER: Well, this PET issue has come up for the last year at every meeting. I mean, that was in the queue long before these things were in the queue. It's a relatively simple issue as Mr. Dobis has stated. We're not going to go back and look at volumes and try to add PET scanners. We're strictly looking at is this -- is this the best boilerplate language so patients could have access to PET? That's all. It's really a relatively simple issue crossing HSA lines. It's not going to increase the number of PET scanners. I think a workgroup could get the language to Jan and Jan could present it to the Commission. It's a couple of real simple things. As far as Mr. Meeker's comments that some time in the future, a couple of years from now, on the issue related to PET -- we will need a SAC; we don't need one now.

MS. TURNER-BAILEY: And I heard that -- those comments earlier. The comments I heard from commissioners is that we're leaning more towards that we probably do need a SAC. And so that's really, I guess, the question. Did you want to make a motion to set something like that up at this time? What's your feeling?

MR. MAITLAND: This is Mr. Maitland. I hate to confuse the issue but as far as the law is, Dr. Sandler, all he has to do is make a motion as to a change to a standard, in my mind, and if we accept it, it goes out to public hearing. You don't have to have a workgroup or anything else. Can't you decide on yourself if you've got such a good idea? And then that's -- if you're complaining about getting it moved along, that's --

DR. SANDLER: I'm delighted to hear you think I might have a good idea. Mr. Christensen will be given language that he can present to the Commission. We'd be delighted to have -- review it, with Mr. Styka's help, of course.

MR. MAITLAND: Am I wrong?

DR. SANDLER: No.

MS. TURNER-BAILEY: Public comment? We have three people in particular who have asked to speak during the course of public comment. We are running dangerously close to our end time, but I know people

have been sitting here waiting all day. So I want to allow the public comment and just to ask if you could, please, be expeditious in your comments. Dr. Bates, did you want to speak again? Of course you do, because this is a different issue.

DR. BATES: Thank you very much. I'll be brief, in view of the time. Again, I represent the American College of Cardiology, Michigan chapter. I'm here to speak to Section 11 of the standards for cardiac catheterization services. I previously raised this issue at the September 2003 meeting. In the interim, the idea's to change the volume standards, which require individual physician reporting and substituting for them, hospital level reporting of outcomes and process has matured within my professional group. I believe I have support from the regulatory agency here. I believe I have support from Blue Cross/Blue Shield in suggesting that these numbers are of historical interest only. They're not useful in measuring the excellence of an individual physician. And what we're offering as an important substitute is actually a fairly radical suggestion. And that is mandatory participation by both diagnostic and therapeutic cath labs in this state, in a registry run by physicians known as the ACC National Cardiovascular Data Registry, which would involve having all the labs in the state using a common reporting form, which would allow us to encourage improvements in process, to monitor quality indicators and to set a new standard in medicine, not just in cardiovascular diseases, on quality initiatives -- and quality improvements. So I've made my argument before. I have a handout that's on the back there that you can review. My proposal is strongly supported by my organization. There's a letter of endorsement from the American College of Cardiology president. There's a letter of endorsement co-signed by the chairmen of this registry and the subspecialty group is the National Society for Cardiac Angiography Interventions. That president also strongly endorses. This concept of doing databasing in cardiac cath labs is probably our strongest quality initiative in our profession, something we strongly believe in. And it would be a very strong step forward for this state to adopt this issue and to rewrite right out of the CON document the previous outdated concept that numbers are the same as quality and that somebody doing 76 angioplasty procedures is -- one year out of training is better than somebody doing 74 angioplasty procedures 20 years out of training. And I think I'll stop short and let you ask me questions. My one suggestion was in view of the CABG concept -- or controversy, and in view of the fact that we've worked on this for the last year, that this might be something that could be very nicely moved to a workgroup to allow public comment, and that it could come back at the next meeting since the language has already been written. And that would be a workgroup and not a SAC.

MS. TURNER-BAILEY: Any questions?

DR. SANDLER: My type of guy, though, not a -- just a workgroup.

DR. BATES: That was actually Jan's suggestion, not mine.

MS. HAGENOW: Do you have any thought of the ramifications of saying this to every cardiology group, that if we took -- made that change, how many people would be able to do that? How many -- I'm wanting some impact of a decision like this versus presently volume.

DR. BATES: All cardiac cath labs should be monitoring their outcomes.

MS. HAGENOW: Well, I agree, they should be.

DR. BATES: They can use it for their CQI in their hospital; they can use it for their accreditation purposes. It's critically important to know the performance of these procedures in the hospital, both from the physician standpoint, the patient's standpoint, the payer's standpoint, the purchaser's standpoint, everybody's standpoint. So the concept is that this is something that should be done at this point in time in the history of medicine, that we're out front with the methodology to do this; we have the scientific background on how important it is, and this is where medicine should go. And it should be a win/win situation for all the people that are involved with us; patients, physicians, hospitals, regulators,
purchasers, payers. The idea --

MS. HAGENOW: Well, my question is maybe too technical and that's why it needs to go to a workgroup or something. But I'm wondering what computers, what software, what you need within cath labs, and what the

ramifications are to make a policy statement that everybody in the state is going to -- that's going to do this program and be legitimized has to have this.

MR. BATES: Yes; that's a key question. I'm sorry I didn't understand it. To produce a maintenance program, one has to buy software from one of 16 vendors that's approved for use in this consortium. One has to have a person to fill out the boxes, which is now done on electronic screening. In return, there's a quarterly report that gives you your hospital data, benchmarks it nationally, and there's a year-end report that gives you the year-end summary of the data that you can use for CQI purposes. So it depends on the lab volume. A hospital doing a low number of procedures might need one FTE, a hospital which is much busier might need more FTE's. But I would, again, state that there are currently 16 hospitals in this state of the 65 participating in this registry, there's 17 hospitals out of 32 with angioplasty privileges participating in a regional database called "DMC Squared" (phonetic) and that 31 of the 32 hospitals with open heart surgery programs are participating in a similar SDS database where these data are being collected. Cardiac catheterization and bypass graft surgery have been the two procedures that have been most under the microscope in the last 10 years, and because of that we have the most advanced experience and methodology and publications on how this works. Everybody's been very pleased with it.

DR. SANDLER: Time is of the essence, so I'm going to make a motion that there be a workgroup formed to look at this and to make a recommendation with language and Mr. Christensen can then forward this, so that the Department is comfortable with it, to the Commission. In the literature which Dr. Bates has pointed out, Stan Nash did not give the data for individual operators anyway. I mean, if you want to review some quality, then you're going to have to look at something else anyway. But since this is so well-established, it would be obvious that we need to look at what Dr. Bates has presented. In fact, frankly -- I hate to say this -- this is as much as a slam dunk as I can figure out. I don't see where the negatives are here. It's a much better quality improvement program than we have now.

MS. HAGENOW: However, the question would be what's our standard if it falls below? If we implement this, and we say it's a requirement, we're in the standard business which means that we would say, then, that if somebody falls below such and so -- there's some action. Otherwise we're getting into the --

MS. TURNER-BAILEY: Wouldn't the standard just be if you submit your data to the data registry, you've met the standard?

DR. SANDLER: Yeah. And it's published and consumers -- Mr. Horwitz can have his brochure out. As consumers, we would be aware of the fact that certain institutions would not be where one would send a loved one for cardiac cath.

DR. BATES: Someone who's collecting these data and submitting to a database such as this, they are above the standards. There's only a minority of hospitals in the country that do this activity in such a standardized format. Most people do it at a hospital level.

MS. HAGENOW: Right. I realize --

DR. BATES: I think the standard would be that if you want to have a cath lab, this is one of the obligations you have, to furnish this service. And that is the standard, that you participate.

MS. HAGENOW: Oh, so it doesn't matter what the outcome is, the public will decide?

DR. BATES: I don't think you want to get in the idea of -- in the field of evaluating outcomes. I think what you want to do is assure that the laboratories are involved in a CQI process where they are working actively on a daily basis on their process and they're monitoring their outcomes and they're adjusting their practice to keep up with current data and state of the art care. I don't think you want to say 76 is better than 74 or that doctor is better than that doctor. You just want to make sure they're doing the right process things.

MS. TURNER-BAILEY: I would like to say that. I don't know if we -- how you say that.

DR. BATES: I don't think you can.

MS. TURNER-BAILEY: I guess that's what's concerning me about this whole discussion is. It moves completely away from -- I guess I can't really believe that submitting your data to a data registry magically improves the quality for everybody, I don't -- unless I'm missing the connection between the two. And what concerns me is moving away from standards that we can put our fingers on, even if they happen to be slightly arbitrary, like, you know, who says 200 is better than 210 kind of question. But just to say we're going to make everybody put their data in this registry and so therefore, you know, quality is going to improve, I don't -- I'm not really seeing that.

DR. BATES: Yeah. That also is very important point. Just putting the data in the registry clearly is not enough. You have to act on the data. You have to look at how you're compared with the other hospitals that are doing the same procedure and you have to put that quality improvement part into it. The data gives you the ability to evaluate how you're doing. But the next piece is to change the practice to make sure you are doing the improvements that your data might suggest are necessary.

MS. TURNER-BAILEY: And we have no way of making sure that happens.

DR. BATES: I would argue that numbers are entirely arbitrary, not based on science anymore. It might be useful from a regulatory standpoint. But, again, as we argued earlier with the bypass graft argument, using a number for regulatory purposes has major limitations in evaluating quality of care or improving process, or improving outcomes. And that's why my organization strongly supports this as is detailed in these letters of support I've offered you today.

MS. HAGENOW: I think it's real commendable, the direction that you're wanting quality to go in cardiology. I have utmost support for raising the bar that way. I'm just questioning the purview and domain of whether the Certificate of Need is about setting the standards for the program of cardiology at a particular hospital system, and that the rest of what you're talking about is something that is done probably through the publishing in the Economic Alliance and other things for which it then becomes a competitive world of looking at quality. And I'm not sure it's our standard business. But I think that's very technical and really gets to -- maybe the workgroup can perk up the arguments about why "yes" or "no."

MR. BATES: I don't think there's anything in this Certificate of Need document on cardiac catheterization that has anything to do with quality or standards of performance or outcomes. I think it's facility hurdles that people have to get over from a regulatory standpoint to have a lab renewed or to buy a new lab. So I think there's a big disconnect behind -- what I see this documenting representing and what this committee does in my couple visits to the committee, and this quality piece, the outcome piece, credentialing piece, privileging piece, which is much more complicated and it really belongs, I think, in the hospital domain or within the cath lab director domain.

MS. TURNER-BAILEY: It feels complex to me.

DR. BATES: It's very complex.

MS. TURNER-BAILEY: Maybe it's because I don't understand all of the issues. But --

MS. HAGENOW: Did he make a motion?

MS. TURNER-BAILEY: He did make a motion. I didn't hear a second, though.

DR. YOUNG: What's the Department's concern on this issue?

MR. HORWITZ: Can you take the rest of the public comment that might be on this issue?

MS. TURNER-BAILEY: Yes.

MS. ROGERS: I really think before you -- this is Brenda. Before you move forward, you need to either get a second on this motion and then move forward from there with the discussion or --

MS. TURNER-BAILEY: Well, the motion was made; there was no second. So I interpret that as the motion dies.

MS. ROGERS: Okay. Thank you.

MR. CHRISTENSEN: Can I respond to Dr. Young's -- the position that the Department has on it is that we do think quality is a very important element of C of N. And we think oftentimes -- as we've looked at the standards that we've adopted over the years, oftentimes we do things based on how many providers we're going to allow into a community and much of our standards are written to that effect. Occasionally we use surrogate indicators, like numbers of procedures, that sort of indicate -- and there's some debate now in this Commission about whether or not there is any science behind the numbers. But at the time they were adopted, there was some reason to believe that higher numbers led to better outcomes in morbidity and mortality. I think we have to be attentive to new ways of ensuring quality in health care. And to the extent that those standards are appropriate for adoption into C of N standards, we ought to include it. And perhaps it's just one of several standards. Maybe there's a numerical number and maybe there's a participation in the data collection registry for quality improvement. Because that's probably the only way you can use C of N to enhance quality, is to require people to participate in the collection and review of data that looks at outcomes and morbidity. Some of the standards that we have adopted require Stan to try and find data. And frankly, the data in many cases is not reliable, it's not complete, it's not thorough. And so in some sense, participating in a more systematic collection of data gives more information for everyone; more information for the Commission and the Department to make decisions, more importantly, more information for that institution to make decisions about how it chooses to improve its quality of care. So participation in data collection or registry systems probably has some merit. Now, I don't know how we stand directly on the two issues, the open heart surgery and this particular proposal. I do think it requires some review and discussion. I did suggest that at a minimum, a workgroup would get together, figure out what the major issues are, and perhaps, like Norma's workgroup, come back and say, "This is really pretty deep water, we need a SAC." I don't know that we can support another SAC on top of the three we've created immediately, at least until we get some of the new staff on board. So -- but maybe there is a workgroup that could ferret out what the issues are in this arena, bring it back, make a recommendation as to whether they think they can complete their work or there's a need for a SAC to more thoroughly delve into it.

MS. TURNER-BAILEY: And I'd be willing to consider that. Yes, Commissioner Deremo?

MS. DEREMO: As I go back to the bylaws on general purpose for the Certificate of Need Commission, it is our responsibility to look at the availability and accessibility of quality health services at reasonable cost and with reasonable geographic proximity for all people in the state. What it seems to me that we're talking about is a higher level issue. In my tenure here -- my brief tenure here at the Commission, we've looked at issue by issue except for the bed need methodology, which was to say what is a better methodology for access. We haven't, in my opinion, at least from what I understand, begun to take this issue of quality and say, "Strategically, as a Commission, how do we move from using volume as a proxy for quality to a higher level of specificity for evaluating quality?" Now, a database may be a step to more in depth ability to measure quality in the future. But I think that would be helpful to have that in an over-arching framework of where we could see the Commission work in terms of quality as evidence-based medicine becomes more standardized and more available than it has in -- anytime in the past. So it may be worth the Commission's time to really think strategically not only where we are today but where we would like to be in terms of the kinds of measures that we would use as a Commission to measure quality as well as accessability and availability. That could provide a framework for everything else that we do.

MS. TURNER-BAILEY: Which I think still comes back to the issue that this is really not -- it's not a simple issue to deal with.

MS. DEREMO: No, it's not.

MS. TURNER-BAILEY: You know, are volume standards the way we're going to go? Are we going to try to take some other route to evaluating and holding accountable those entities that come under CON, which is

another issue that we have to deal with because -- that's what I'm concerned about right now is, you know, if you make everything so broad and vague that we can't ever say "yes" or "no," I'm very concerned about that.

MS. DEREMO: That was not my point that you make it broad and vague, but that we develop a strategic principle that as we look at SAC's, that we become more and more specific to get us from using lower level quality standards to high level quality standards, and maybe have a process for getting us there. Am I making --

MS. TURNER-BAILEY: I was agreeing with you.

MS. DEREMO: Oh, you are? Sorry.

MS. HAGENOW: I think we're back to the workgroup. And even though we let the motion die --

MS. TURNER-BAILEY: Well, there was a suggestion for thinking about a workgroup that would come together and sort of formulate the issues for us.

MS. HAGENOW: Yeah; formulate the issues --

MS. TURNER-BAILEY: I'm not in disagreement with that, personally.

MR. MAITLAND: Are you seconding this, Renee?

MS. TURNER-BAILEY: No; not yet.

MR. MAITLAND: Is Dr. Sandler seconding his prior motion? You know, another thing we used to do in the past is have the Department review this information. I got lost somewhere along the way, and I apologize. I heard chimes in my head or something. But maybe the Department could review it and come back and make a recommendation at the next meeting as to this -- what Jan was speaking of.

DR. SANDLER: That would be just delightful.

MR. MAITLAND: And we used to do that.

DR. SANDLER: The advantage of the Bill 619, it allows various avenues to improve the CON process. Everything doesn't have to have a six-month SAC. It's a relatively simple issue. And I think this is, frankly, an issue that really doesn't need a SAC. Would you -- Renee, would it be acceptable to you as the chair to have Mr. Christensen and the rest of his colleagues look at this and report back to us –

MS. TURNER-BAILEY: Yeah, either way. I really think that the question is, you know -- I think -- I'll speak for myself. I would like to hear more about what the issues are that we think we need to deal with and that we can deal with, within the purview of our -- you know, what we're able to do legally.

MS. HAGENOW: The boundaries; yes.

MS. TURNER-BAILEY: Yes; within our boundaries. And so I would certainly appreciate some input about that from the Department or workgroup or some combination of the two.

MR. CHRISTENSEN: The Department would be interested in putting together an issue paper around this for the consideration of the Commission at its next meeting if Dr. Sandler and Dr. Bates and perhaps others that might be interested would be willing to meet with us and help us ferret out the issues.

MS. TURNER-BAILEY: Well, I'd like to ask that you do that, if the rest of the Commission is amenable. Okay. I"m hearing consensus. I don't think we need a motion to that effect.

MR. STEIGER: Madam Chair, are we done with public comment?

MS. TURNER-BAILEY: No; still doing public comment.

MR. STEIGER: I had submitted a card.

MS. TURNER-BAILEY: Was that this card?

MR. STEIGER: Barely legible, perhaps.

MS. TURNER-BAILEY: I'm sorry. I couldn't read it. Okay. Of course, Mr. Steiger.

MR. STEIGER: As Meeker said, I'm still Steiger from Blue Cross. And Dr. Bates had mentioned Blue Cross early on in his presentation, and I just wanted to point out that we've had some preliminary discussions with Dr. Bates and, quite frankly, when I first heard his proposal over the phone a week or so ago, I was quite enthusiastic about it and I still am. I think what the ACC and what Eric is trying to do is certainly something that needs to be done in the state. In fact, one of the physicians that I'm working with at Blue Cross had even submitted some language that would allow a participating hospital to participate in a databank, whether it was the ACC databank or Blue Cross or somewhere else. We do have a voluntary database that is voluntary for our hospitals that belong to our Centers of Excellence program. But in talking to Dr. Bates I had quite frankly forgotten until I hung up with him that the major problem that I see is that facilities that currently have cardiac programs would not necessarily be forced to participate -- wouldn't be forced to participate in this kind of a program. People are not grandfathered in. They are approved under the standards that exist whenever they're approved. And while this may end up being a good process, we certainly aren't able to force all of these facilities that have been approved prior to this to get into this kind of a database program. So I guess I'm here to support what he has to say, in general. I'm also here to support what Mr. Ball said and that is that we really need a Standard Advisory Committee to work on this. I don't think it's something that can be handled in a informal workgroup. I think it's a little more complicated than that, and I think it needs to have the light of day shown on it. So I would urge you to, at some point, appoint an advisory committee.

MS. TURNER-BAILEY: Thank you. Any questions? (No verbal response) Did you have a -- I have your card. Larry Horwitz?

MR. Horwitz; I saved the comment on this, because I think this is a issue of the fundamental importance, what of CON has a value? Why do I say such a strong statement? What the College of Cardiology's Dr. Bates has recommended is to say instead of requiring programs and physicians to meet certain standards of quality, which so far we've operationalized as a proxy of volume -- there's a lot of stuff in the literature that says there's a correlation, as Dr. Sandler has mentioned, between volume and quality. We may disagree about the right number, but there's a correlation. Instead we'd vacate those minimums and instead have the programs be required to participate in a data system. But the data would not be available to people. All they'd be able to give us is to say that Hospital X is submitting data. We would not be able to be told whether or not that data indicates the facility or the doctors participating were of high, medium, low, or uncertain quality. So it will not generate for us anything that consumers or purchasers can use in making judgments of going to this place versus that place, or this doctor versus the other. If and when there could be indications of quality, that would be more sophisticated than raw volume; right? Outcome's far better than quality; right? Severity adjusted outcome measures, that would be a -- we've said when you get there, let's junk the minimum numbers of volume procedures and go to these outcome measures. But that's not what's being presented to you. What's being presented to you is drop the crude indicators of quality you have now and substitute for it that they will participate in a private sector, non-governmentally regulated process of providing data where the public doesn't get any output from it. We don't have any objection to having the Department ask all programs in the state to please participate in the program. I don't think they can legally require a program to participate in a private sector data collection program. They can say, "You can have the choice of either providing the data to us or providing the data to them in lieu thereof." But you can't have government require a private sector entity to go participate in some other private sector entity and pay them money to do that and -- not to mention Dale's point that it would take, you know, five, seven years before each cardiac program in the state would come up for an upgrade such that they would be required to participate. But the most fundamental issue is the one I started with. Good heavens, don't scrap the quality indicators we have now. Let's talk about encouraging and promoting cardiologists and others getting

together to perform better measures of quality, but such that you don't drop the volume numbers until such time as you have publicly available, quantifiable, comparative validity tested measures of quality. Otherwise you're not meeting your requirement to meet quality. And while facility volumes are a very important issue, because it is a proxy for the people that can't move around, namely the technicians, the nurses, the -- everybody else, they don't move around -- but every study I've seen says that the practitioner volume is even more important than the facility volume. It ain't easy. But since all these hospitals keep records of whether Dr. Jones or Smith did how many, if you asked enough -- if you asked all the programs -- Stan's got a way of doing it for MRI, which has worked very well, which is any particular doctor may have been referring people to a multiple number of MRI units and he collects all the data and he figures out how many each of these doctors are doing. It's very hard but it can be done. So I'm thinking, don't throw out what you've got now and substitute it for the lack of any kind of quality measure. And the reason I'm concerned about this is for you to say, "Yes, we believe in this," you're in effect sanctioning by some way the idea of scrapping minimum volume numbers in lieu of the -- sending data to some group is a good trade. I would hope the Commission wouldn't do that. Now, he mentions he's talked to lots of people. I would invite Dr. Bates to the podium but he's gone --

MS. TURNER-BAILEY: He's waiting -- he's right behind you.

MR. HORWITZ: I want to have -- invite Dr. Bates to have -- so we can arrange a time when the college can come in and meet with an array of purchasers among our membership. We'd like to hear about this. Thank you.

MS. TURNER-BAILEY: Yes. Dr. Bates?

DR. BATES: If I could just have one minute to redirect Larry again. Number one, you have no criteria right now by which to evaluate physicians because you can't measure the volume. You're not measuring the volume. You haven't used this particular point in the CON since it's been put in the CON. Number two, I guess I assumed that some of this language might have been circulated, and it has not. Larry Horvath has written up some tentative language to play off of, and it does include the fact that by having all these hospitals work on this one data system, they would all be using the same forms, there would be a one-year report for each hospital that would be submitted to the Community (sic) of Public Health, so in fact, you would have all the hospitals -- all the cath labs in the state reporting data using one common data form to the Department of Community Health, which amounts to public reporting, which I think is what Larry Horwitz should be ecstatic about.

MS. TURNER-BAILEY: We have a serious time issue here. I don't want to -- I hate to end the meeting without having heard everyone. But I think --

DR. SANDLER: Let me just -- Dr. Creelman has been waiting very patiently for six hours here for a five-minute presentation.

UNIDENTIFIED SPEAKER: And I have two citizens here from Hillsdale with an interest in making a public comment on their psychiatric bed issue.

DR. SANDLER: Yes; equally important.

MS. TURNER-BAILEY: I certainly wasn't getting ready to discount anyone's time in any way, shape or form. I, unfortunately, am not going to be able to stay. But certainly we want to get through the comments if we can. I'm going to have to excuse myself. Commissioner Hagenow's going to take over. But before I go, I would like to just take a moment to acknowledge and thank Commissioner Delaney. This is going to be his last meeting. He has served the Commission diligently and faithfully for -- how many years?

MR. DELANEY: Six.

MS. TURNER-BAILEY: -- six years. And I would just like to take a moment to really thank him for the work that he's done and for the efforts he's put into bringing us to where we are today, and just hope that you would help me to acknowledge that. Thank you.

MR. DELANEY: Thanks, Renee. It's been very much a privilege. (Ms. Turner-Bailey, Mr. Goldman, Dr. Young, Dr. Ajluni and Mr. Styka leave room)

MS. HAGENOW: So on this same issue have we completed all of them on the cardiac cath? (No verbal response) So where we are at with the cardiac cath is that it's to the Department for a white paper, and there are folks that you're going to tap that are going to be willing to assist?

MR. CHRISTENSEN: (Nodding head in affirmative)

MS. HAGENOW: So then we move to Wayne Creelman of the Pine Rest Christian Mental Health Services.

DR. CREELMAN: Thank you very much, honorable CON Commission members. I'll be very focused and do my very best to hold it within 10 minutes. My name is Dr. Wayne Creelman. I'm the executive vice president and chief medical officer of Pine Rest Christian Mental Health Services. I'm also the medical director of a joint operating agreement that Pine Rest created six years ago with Metropolitan Hospital and St. Mary's Health Care in the Grand Rapids area. Incidentally, I'm also the president of the state psychiatric society, which in some way covers all psychiatric beds, I guess. I'd like to thank you for the opportunity to testify before you today on the issue of occupancy standards for adult psychiatric beds. The current standard of 90 percent occupancy for all adult psychiatric hospitals or units in a planning area -- this is from Section 6-2 -- has had a very negative impact on access to care for all psychiatric patients, both public and private. We are respectfully requesting the Commission to change the standard today, or at minimum, requesting that the adult psychiatric bed standards be added to the Commission's work plan. Pine Rest Hospital, along with St. Mary's Health Care and Metropolitan Hospital developed a joint operating agreement to care for the adult Medicaid recipients of psychiatric services. These are folks 18 to 64. This successful collaboration has continued to experience the problem of turning away potential clients in our community due to the lack of adult psychiatric beds. Over the past two fiscal years, we've turned away approximately 700 requests for adult admissions due to the lack of available beds. These individuals have been forced to seek treatment long distances from their homes, families and support structures, or at more costly alternatives. We've consistently experienced being potentially over-capacity because of jail holds, court-ordered involuntary admissions from outside our planning area, and the preference of consumers to utilize our inpatient programs. Due to the unique nature of psychiatric inpatient care, it's very difficult for adult psychiatric units with semi-private rooms, double occupancy, to reach a census consistently over 90 percent. Our clinical experts, our docs, have shown that semi-private rooms provide an absolute necessary tool in the treatment of severe or acute mental illness, so the development of costly private suites is really not a feasible solution. I mean, just like -- patient safety issues, patients who are agitated, patients who we are holding on behalf of the jails who are, perhaps, in a three-bed room, I'm sure none of you would want to join that individual who's in there for major criminal behavior, sleeping at night with your own agitated difficulties or depression; it simply isn't an atmosphere conducive to corrective behavioral issues. And so now we've got two empty beds already out of those three on a particular unit. And it never fails that when you've got one bed open in a two-bed room, it's the wrong sex that comes in at 2:00 o'clock in the morning. It's never the same sex in order to fill that double. According to the Michigan State budget office, the population in Michigan has grown 8.1 percent in the last 12 years. However, the number of licensed adult psychiatric beds has significantly decreased in the same time frame, according to the Department of Consumer and Industry Services. The numbers are that back in '88 to '89, we had 4,191 beds. Last fiscal year, '02 to '03, we had 2,292, just to give you some specific numbers. According to CON section review standards, the adult psychiatric bed inventory as of August 12th, 2003, in the planning area, Kent, for both Pine Rest and St. Mary's, has 12 beds in the inventory not currently in use. With the governor's recent Michigan Mental Health Commission report, dated October 15, 2004, the Commission stated in its executive summary on page 4, goal 3: "A full array of high quality mental health treatment, services, and supports is accessible to improve the quality of life for individuals with mental illness and their families." And in the Commission's key recommendations on page 37: "MDCH, in cooperation with other state departments, shall establish a clear policy and time table to have in place a comprehensive, high quality, statewide service array that will increase the volume of appropriate services and improve quality of care, give consumers and families increased confidence in the system's ability to respond effectively to recipients' requirements." Pine Rest, St. Mary's, and Metropolitan are asking the Commission to consider changing the standards for average occupancy rate for adult psychiatric hospitals and units from 90 percent in the planning area to 85 percent. That's statewide. And you have

Attachment 1 on the proposed standards change on the second page of the material that you were given prior to the meeting today. And I did pass out an attachment earlier entitled "Attachment 2." That shows you that if you take the -- and this is the state CON Commission data -- I should say the state data on the potential impact on making this change. If you assume the census data for February of '03 in the planning areas for average occupancy, any area that would even get over 70 percent at the new 85 percent occupancy potential would require an additional 17 beds to be utilized in the state. 12 of those would be in the Kent planning area. I'm happy to take any questions.

MS. HAGENOW: Any questions from the commissioners?

MR. ANDRZEJEWSKI: Dr. Creelman, what's your occupancy rate for the children's unit?

DR. CREELMAN: The -- I've got some statistics. The children's standard is very different. It's 75 percent occupancy. We're not -- I'm not here today to talk to that issue; just the adults.

MR. ANDRZEJEWSKI: I'm just wondering about the flexibility of the use of the beds, if that were made available to you. Does that solve your problem or doesn't it?

UNIDENTIFIED SPEAKER: We've got 12 beds -- adolescent beds that are currently not being used. They're on mothball.

DR. CREELMAN: I'm not sure that actually solves our problem, sir. I don't know if I have the statistics on the actual occupancy of our kids. Yeah; I don't think it's a possibility to do that, quite frankly, without a major initiative. Lody, can you respond to that?

MR. ZWARENSTEYN: Yeah; right now the standard -- there are separate licensing for adult and children. The Department has taken the position in so far informal discussions that they are inflexible on that; that separate licensing would apply.

MR. ANDRZEJEWSKI: Can we get people to identify themselves for the record so --

MS. HAGENOW: Yeah; he's got a card and do you -- do we want to entertain Lody to come up here -- or Lody now and then we can direct questions at both? Or do you want to answer that question from the Department? (Off the record interruption)

MR. CHRISTENSEN: My understanding is that there are separate licenses for psychiatric beds for children and for adults. The amendment, which I think you were alluding to, Roger, is that if they're the same facility or the same organization, could we amend that standard to allow some float between the vacancy rate in the children's bed and the adult bed, where it was appropriate to do that.

MR. ANDRZEJEWSKI: My issue is if that amendment were available, does that solve their problem? Does that give them enough bed flexibility to solve his problem?

DR. CREELMAN: The actual beds that we have are in the Pine Rest system. They aren't in the joint operating agreement. Those are 94 adult beds only.

MS. HAGENOW: Next is Lody Zwarensteyn?

MR. ZWARENSTEYN: Okay. I'm Lody Zwarensteyn with the Alliance for Health, and I'm here to support Pine Rest. There are two options on this particular option. One is as Pine Rest had indicated, if we could change the occupancy standard from 90 to 85 percent, that will provide some relief. The other is -- as Commissioner Andrzejewski suggests, if there were a way of looking at the licensing, that would be, in my conversation with the Pine Rest officials, another option that would also help solve their problem. But the Department does license separately. And it would take a change in licensing, which could be done conceptually. I don't know what the timing of that is, and Mr. Christensen, I'm thinking, would probably suggest it's a little more difficult to do than to say. It would be easy for you even today, as long as there's six of you here to say, "Let's just change one number" and that would do it. I do want to suggest something to

you that I would like you to think of. And it's something that we've discussed with Pine Rest very seriously. The bed complement at Pine Rest today is significantly less than half of what it was 10, 15 years ago. Pine Rest has done a very good job of removing excess beds from its license. It didn't have to; it did that. It now is also operating with a joint agreement with two other acute care hospitals so as to allow for Medicaid funding, that they not be declared an IMD and not eligible for Medicaid reimbursement. They've cut their beds, they've been working with others. We talked to them years ago about those cuts. And we said if they would make a sincere effort to right size themselves, at the time they needed more we would go to bat for them. And that's what we would like to do right now. They've cut, they've been working with others. They're noticing that they're very tight. So in some form -- whether it's the occupancy -- which you can do by the stroke of the pen under the new law right now -- or directing the staff to see if you could do something on licensing, it is something that is within possibility, either way. But we'd ask you to act on this.

DR. SANDLER: The hour is growing late. I will declare a slight conflict of interest. I do know Dr. Creelman prior to this meeting through organized medicine. He's also the immediate past president of the Kent County Medical Society. I have no -- I have no cumulative interest, however, in Pine Rest psychiatric beds.

MS. HAGENOW: What's the pleasure of the commissioners on this?

DR. SANDLER: I'm going -- I'm going to make the motion. The motion is that we accept the language that Dr. Creelman has put forward and this will solve the problem. Looking down here, it's basically a problem in -- only in Kent County. The fact that the local planning agency has worked hard on this is good enough for me. And the motion is that we accept the language for the change that Dr. Creelman's recommended.

MR. MAITLAND: I'll support, so we can have discussion.
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MS. HAGENOW: Okay. Is there a second? Oh, I'm sorry. You just seconded. Okay. Discussion?

MR. MAITLAND: The process is we come back at the next meeting, we vote on it again, and then go to public hearing? Or do we have a public hearing -- or do we never have a public hearing?

DR. SANDLER: We have a public meeting before the next meeting.

MS. ROGERS: This is Brenda. If you take -- I've got to think a moment. If you take action on this today, which would be considered proposed action and move it forward to public hearing, then we would schedule a public hearing and it would come back to you at the March meeting for final action, if that's -- according to what Dr. Sandler's motion is.

MR. MAITLAND: Which his proposed action is only to change the one word, the 85 percent.

DR. SANDLER: Change 90 to 85 only.

MR. MAITLAND: And your motion was to put it out for public hearing?

DR. SANDLER: Bingo.

MR. MAITLAND: Okay. I still support that, then.

DR. SANDLER: Thank you.

MS. HAGENOW: Okay. So we have a motion -- yes?

DR. CREELMAN: Yeah, may I just clarify? At some later point, we would then apply for those 12 beds. But this is not the action at this time that we're proposing; it's just the 90 to 85.

MR. ANDRZEJEWSKI: I have another question as a possible alternative. Is it possible to re-license some of the beds he gave up, based upon his attendant circumstances rather than changing the law that affects everybody?

MR. WHEELER: I'm Walt Wheeler from the Bureau of Health Systems. We license psychiatric beds. I mean, we're willing to look into anything and what the circumstances are, but I'll give you a straight answer to a straight question. Once they're de-licensed, they're gone.

MS. HAGENOW: So the question is whether there is deep ramifications of moving from an occupancy of 90 to 85 as a requirement, across the board. What ramifications is there in that, that would be --

DR. SANDLER: Well, he's passed out this sheet that the most you could have was an increase of 17 psychiatric beds in the entire state. And since there's more than 17 schizophrenics out there wanting in beds, presumably those 17 beds are then needed. Most of them are in the Kent County that he's talking about. It's pretty straightforward to me.

MS. HAGENOW: Any -- Jan?

MR. CHRISTENSEN: The Department would not be opposed to sending this out for public hearing but would want to withhold judgment on it, then make some point of view. I want to check the data set, make sure it's all complete, make sure the implications aren't there. So we certainly recognize the problem that's happening at Pine Rest and we're willing to work on a solution for that and work with Lody and the local agency to do that. So it's not -- I think this is one of the issues that doesn't need to go to a SAC; that we can send it out. We'll come back; we may recommend 87 percent or something -- I don't know what it would be, but it may be slightly different than what's here. But it seems like it's okay at this point.

DR. SANDLER: My concern, let's get the ball rolling
and we'll figure this out in March.

MS. HAGENOW: Ready for the question? All those in favor of reducing the standard from 90 to 85 pending a review as well and going through public hearing, right hand up. ALL: (Affirmative response)

MS. HAGENOW: Just enough votes.

DR. CREELMAN: Thank you very much. We appreciate it.

MS. HAGENOW: Now, we have Don Nielson (phonetic) from Hillsdale.

MS. LOWES: I'm not Don, I'm Joan Lowes, attorney for Hillsdale Community Health Center. I'd just like to comment briefly before Mr. Nielson comes up with his comments. As you'll recall, I was here before you on September 14th, asking you to initiate the process for reviewing and revising the psych bed standards to afford some relief to Hillsdale, who is unable at the present time to qualify under the standards. And the reason is, as you will recall, that Hillsdale and Jackson are combined. Those two counties, they are in a combined planning area. And there is currently an inventory of 40 beds, and a bed need of 40 beds. Given the hour, I'm going to turn the mic over to Mr. Nielson and Ms. Baker, who have come up from Hillsdale to provide you with some firsthand information about the problems that that hospital is experiencing with psychiatric patients.

MR. NIELSON; Good afternoon, I am Don Nielson, and I'm a certified social worker, speaking on behalf of Hillsdale Community Health Center. Hillsdale is the only health center in Hillsdale County, which is classified as rural and we have a population of 47,000 individuals. We treat a high percentage of Medicaid and uninsured patients, and we average 30,000 emergency room visits per year. The hospital is classified for Medicare purposes as a rural referral center, due to its high number of admissions and complexity of the cases that we handle. Presently we are licensed for 86 acute care beds. We currently occupy 73 of those beds. And of those 73, 21 of those beds are our skilled nursing unit. We desire to initiate a 10-bed adult psychiatric unit. Under the current Certificate of Need standards, Hillsdale does not qualify because the standard shows no needs for beds in the Hillsdale/Jackson area. The experience of the hospital and the

community of Hillsdale quite clearly show that there is a defined need for psychiatric beds in our area. Time and time again, the hospital has encountered great difficulty locating available beds for patients brought to our emergency department who are in need of this specialized care. Today, adult patients who need inpatient psychiatric care are sent to Jackson, Coldwater, Adrian or Marshall, all in excess of 25 miles from Hillsdale. In fiscal year 2004, there were 98 inpatient stays arranged by Lifeways, which is the community mental health agency in our area, for Medicaid and uninsured patients. This group represents only 60 percent of Hillsdale's psychiatric admissions. While waiting for inpatient beds to be identified in another town, patients in need of inpatient mental health services often spend long hours in the hospital emergency department. Some of these patients are confused and agitated. Some require constant watching because they wander. Others become disruptive while waiting for needed treatment, and threaten the safety and well-being of hospital staff and other patients. The Hillsdale County Sheriff and Hillsdale Police Departments are often called in to assist. When beds are identified, the patient must be transferred many miles over country roads. This situation is both dangerous and unnecessary and must be addressed. Furthermore, patients with psychiatric conditions and medical conditions are often admitted to Hillsdale Community Health Center to stabilize them from a medical standpoint. They are sometimes housed in the intensive care units so that staff can constantly monitor them. They unfortunately disrupt the other patients without psychiatric diagnoses, and their confusion and agitation is often increased when they are placed side by side with those with serious medical conditions. Hillsdale does not have a psychiatrist on staff to treat these patients, and the hospital cannot attract a psychiatrist unless we can offer the ability to admit patients to a mental health unit at our facility. Finally, many patients in Hillsdale County who are released from inpatient care struggle to continue with psychiatric treatment on an outpatient basis due to the distance that they must travel. Unless and until there is a change in the standards, Hillsdale will not be able to have a much needed psychiatric unit. We urge you to rectify this situation. As a start, we have drafted a suggested modification to the standards. It allows for flexibility for hospitals in rural counties like Hillsdale which do not presently have psychiatric beds that are approved, pending or operational to initiate small psychiatric units. We believe this would greatly enhance the ability of rural communities to meet the needs of our psychiatric patients. Thank you for your consideration.

MS. HAGENOW: Thank you. Questions? (No verbal response)

MS. HAGENOW: Denise Baker?

MS. BAKER: Thanks for hearing us out today. My name is Denise Baker. I'm from Hillsdale, Michigan. I've lived there all my life. I'm familiar with Hillsdale Community Health Center. I was born there; all my children were born there, and all my children's children were born there. I can only suggest to you the comfort that it offers to be able to go to a health care facility where you know the people that work there, you know the physicians. It certainly provides a lot of stability; you know who to ask questions of, how to get answers, and what to do. Recently, my adult child developed late onset bipolar. She required hospitalization. We do not have a psychiatrist in Hillsdale, so she had to seek psychiatric care outside of town and based on the desire to commit suicide, required hospitalization. She had to go an hour away from home to be hospitalized. That presented a great deal of hardship for her as well as her family. I'm sure that any of you that are familiar with this type of illness know that they like a lot of familial involvement; particularly with the suicidal issue, it's important. It certainly was important to me and to her husband and children to be involved. I have an administrative position so I could drive an hour there, an hour back and not run into a great deal of difficulty. Her husband, however, didn't have that same benefit; nor were her children able to go see her, which created its own set of problems, based on the fact that she was unwilling to stay the appropriate amount of time because she couldn't see her kids. The other difficulty that we faced by having to go to an unknown facility with unknown physicians was that her medical physician, the person that's taken care of her for the last 17 years, lives in Hillsdale. He could not share any information with her psychiatrist. We could have gone through the process, and that could have happened. But it certainly would have been better for her in the long run if somebody concerned with her emotional health could have dealt with her physical health on the same plane. I would just respectfully ask that you consider that the people in Hillsdale County deserve the opportunity to have psychiatric care in their own community and give us the chance to take care of our own. Thank you.

MS. HAGENOW: Thank you. Any comments or questions? Commissioner Deremo?

MS. DEREMO: Mr. Christensen, do we have the same -- or has there been any consideration to the drive time methodology that we just approved in the SAC related to psychiatric beds?

MR. CHRISTENSEN: No. That was not considered. It was acute care beds that were reviewed. So it's not that it can't be done, it's that it just wasn't done in that particular SAC.

MS. HAGENOW: Any other questions? (No verbal response) Recommendation from the Department on what needs to be done on this situation? Jan or Larry or Brenda, can you give us some guidance in terms of the recommendation, the standard that's not --

MR. CHRISTENSEN: Let us caucus for a minute here.

MS. HAGENOW: You can caucus for a minute, certainly. We're at 4:25. You can caucus for one minute, unless the commissioners in the meantime have some discussion.

MR. MAITLAND: There's -- you know, it's fairly simple language, but I don't know the ramifications. The 85/90 is different. But since they're looking at this, they can certainly, I would think, be able to look at these -- what they're asking, see how that affects other areas of the state. So, again, can we just ask the Department to make some -- to review this and come back with some kind of --

DR. SANDLER: Are you making a motion, Commissioner?

MR. MAITLAND: I don't know if we need a motion, we just did this casually on the other case.

MS. HAGENOW: Perhaps just an appointment to the Department to give us that at the next meeting.

DR. SANDLER: Well, yeah. If we make a motion, send it out just like the previous one, the Department can look into it and we can take final action in March and get things moving.

MR. MAITLAND: Well, I'm not too sure I'm ready to make this -- support that. I'd like to see what kind of ramifications there are. And if it isn't -- if it doesn't affect thousands of beds around the state we can do it in March and send it out.

MS. HAGENOW: Definitely an access issue, it seems, for a particular geographic area. Go ahead.

MR. CHRISTENSEN: Staff believes that if we had a little bit of time to work on this issue we could meet with the provider and meet with other providers in the area and we might be able to come up with an amicable solution within the existing standards that would accomplish the goals that were envisioned. On the other hand, if that's not possible, we could come back in March with some specific recommendations for the Commission.

MS. HAGENOW: Because I think this was here at the last meeting and so we didn't take action. It was again at the end, and our responsiveness is probably on the line here in terms of turning it into something that becomes for real. Yes?

MS. LOWES: Thank you. We'd be certainly happy to meet with the Department and the other providers in the area. We had a meeting last week at Lifeways to get their support, and I think we are -- we are going to be able to get their support for this proposal. This is a problem that's really in need of a solution. Hillsdale is unique in many ways. It's a -- the hospital is unique, the county is unique. It is unlike any other rural county, in my opinion, in the State of Michigan. So anything we can offer to give the citizens of this community the opportunity to have a small unit -- they're not going to be building a new building; they have space that could accommodate these beds. So we would appreciate the opportunity to pursue it in whatever manner you believe is appropriate.

MS. HAGENOW: I don't know that we need a motion, but rather a request from, I guess if I'm -- the acting chair to the Department to see if they can resolve it within the existing standards and if not, to bring it back to the March meeting at which we would take action on your recommendation.

MS. LOWES: Thank you.

MS. HAGENOW: Thank you. Anything else for the good of the order?

DR. SANDLER: I have a motion to adjourn.

MS. HAGENOW: I declare it's done. (Meeting adjourned at approximately 4:26 p.m.)